Dear Members of the General Assembly:

The Department of Drug and Alcohol Programs is pleased to present the *2013 State Plan* to the Governor and the members of the General Assembly on the implementation and impact of the programs funded by state and federal funding. You may also access this document electronically by visiting www.ddap.pa.gov/reports.

State and local governments are facing unparalleled demands – one out of every four Pennsylvania families suffers from drug and alcohol abuse in the family – to meet essential prevention, intervention, treatment and recovery services, with sparse resources. Decision makers in government, as well as taxpayers, are increasingly concerned that every tax dollar be spent judiciously. The public requires and deserves accountability and results; knowing that untreated addiction is a major cost driver for state and local government as well as a major cause of crime, child abuse, health care costs, workplace costs, highway crashes and other societal ills, this principle could not be more important than in the work of this new Department. This underscores the timely and critical nature of this report on the effectiveness and need for a full array of prevention, intervention, treatment and recovery support services.

We must follow the science and insist on programming with positive and cost-effective outcomes. By insisting on programmatic integrity at all levels of our prevention and treatment delivery system we will save taxpayer dollars and, more importantly, will save lives. Preventing the disease and restoring as many addicted Pennsylvanians as we can to the rich life of recovery and productivity, is our mission.

Please feel free to contact me if you have any questions. Thank you.

Sincerely,

Gary Tennis
Secretary, Pennsylvania Department of Drug and Alcohol Programs

Cover Letter from Gary.docx

PENNSYLVANIA DRUG AND ALCOHOL ANNUAL PLAN AND REPORT

DRUG AND ALCOHOL ABUSE PREVENTION AND TREATMENT

2013-2014





pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

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Part 1: Overview and Program Reports

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DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

ACKNOWLEDGEMENTS

The Department of Drug and Alcohol Programs (DDAP or the Department) gratefully acknowledges the Pennsylvania General Assembly and Governor Tom Corbett for the establishment of this important new Department. Without their esteemed leadership, the creation of DDAP would never have come to fruition. This secures Pennsylvania's place as a true leader in the country in addressing the wide ranging devastation caused by drug and alcohol abuse across the state. Our programs, over time, will have a dramatic impact on Pennsylvania's criminal justice system, child welfare, health care costs, the workplace, and highway safety, leading to benefits for all Pennsylvanians.

DDAP also thanks the Pennsylvania Association of County Drug and Alcohol Administrators, the Pennsylvania Community Providers' Association, the Drug and Alcohol Service Providers Organization of Pennsylvania, Commonwealth Prevention Alliance, Pennsylvania Prevention Directors Association, and the Pennsylvania Recovery Organizations Alliance for their support throughout the formation of the Department. Your ideas, advice, and recommendations have time and time again proved invaluable to DDAP.

Without the support from the leadership and staff of numerous state agencies the development of DDAP would have been much more difficult. The expertise and enthusiastic support we have received is impressive, and has made this transition process much easier for DDAP.

To specify, the administration and staff at DDAP thanks the Department of Health (DOH) and the Office of Administration for the generosity they have displayed in providing support services, particularly in supporting the work of establishing the Department. The many hours of hard work DOH and OA have dedicated to DDAP is admirable; without these services the daily operations of DDAP could not have moved forward.

DDAP thanks the dedicated Substance Abuse and Mental Health Services Administration staff for their help and direction during the period of transition from Bureau to a Department. Your contributions have helped shaped the Department in immeasurable ways.

Finally, we thank the DDAP staff for their daily efforts to make our accomplishments and goals a reality.

Gary Tennis
Secretary,
Pennsylvania Department of
Drug and Alcohol Programs

Fellow Citizens of Pennsylvania,

As a career prosecutor and as the Legislative Liaison for the Pennsylvania District Attorneys Association from 1986 to 2006, I have spent virtually my entire professional life looking for how to make Pennsylvania's homes and streets safer from crime. I found the answer in my work as Executive Director of the President's Commission on Model State Drug Laws in 1993, where I learned that three out of four criminal offenders suffer from untreated drug and alcohol addiction. I learned the remarkable fact that if we provide these offenders drug and alcohol treatment that is individually matched to each one's level of addiction, we will reduce recidivism by about 70%. Returning to Pennsylvania, I spent my final years advocating on behalf of Pennsylvania prosecutors for more treatment.

I came to learn in the ensuing years that drug and alcohol addiction, although *the* major cause of crime in our nation, is much bigger than the crime issue. In fact, one out of four families suffers from drug and alcohol abuse, often in secret, and often with devastating results not just to the one with the disease but to the children or other family members. Although Pennsylvania does better than most states, most of those in need of drug and alcohol addiction treatment go without.

I am pleased, but not satisfied, with how far we have grown as a Department in the past year. It seems like we started only yesterday, yet we have hired new key staff from around the country, developed plans for the Department mission and goals which reach across a wide range of priorities, and established strong relationships and collaborations with other key Departments. In this short time, we have worked closely with our stakeholder groups to implement policy changes to improve the quality of care, reduce duplicative efforts and end outdated practices. I have not grown tired of colleagues approaching me with their gratitude regarding how much they appreciate the new relationships that have been forged, and the "breath of fresh air" that has been a hallmark of these growing collaborations. And all of these changes also save taxpayer dollars.

Even with all this growth, I realize there is much to do, that our work has just begun. As I look ahead, I consider, "What can I do to help tomorrow?" "What programs will make the biggest difference while remaining fiscally sound?" I'm reminded of the woman I met, with tears in her eyes as she told me, "I've been clean for 25 years since I got treatment when I was pregnant with my baby. My baby's grown now and we work together, giving back to others who need help like I did." I still remember her smile as she proudly pulled out the picture of her grandbaby. A priceless example of how treatment can change the future for not just one person but for generations to come.

This is our answer. This report reflects the accomplishments of our Department over the past year, as well as our mission and vision as we move forward to the next generation of growth. This answer demonstrates the value of the work on a daily basis, not only in terms of economics, but also in terms of hope, and the quality of life for the citizens of Pennsylvania. This report answers my ongoing questions: "What needs to be done?" and "What can I do to help?" In these pages, I hope you may find these answers as well, as we continue our partnership for the growth of Pennsylvania.

Sincerely,

Gary Tennis
Secretary, Pennsylvania Department of Drug and Alcohol Programs

State Plan 2013 Introduction

In 1972, the General Assembly established a health, education, and rehabilitation program for the prevention and treatment of drug and alcohol abuse through the enactment of the PA Drug and Alcohol Abuse Control Act, Act 1972-63. This law established the Governor's Council on Drug and Alcohol Abuse. The Council was subsequently reorganized through Reorganization Plan 1981-4, which transferred its responsibilities and its administrative authorities to the Department of Health. Act 1985-119 amended Act 1972-63, changing the name of the Council to the Pennsylvania Advisory Council on Drug and Alcohol Abuse and designating the Secretary of Health, or his designee, as the chairperson.

Recognizing that substance abuse affects a huge segment of our population and is a major cost driver in our criminal justice, health care, children and youth, workmen's compensation and other taxpayer-funded systems, the Pennsylvania General Assembly enacted Act 50 of 2010. Act 50 amends Section 201 of the Administrative Code of 1929 by adding the Department of Drug and Alcohol Programs (DDAP) to the other Commonwealth departments performing the executive and administrative work of the Commonwealth. The Act also defines the organizational structure, as well as the powers and duties of the Department. Moreover, as previously required by Act 1 of 2010, the Department of Health, Bureau of Drug and Alcohol Programs was responsible for the development and management of a compulsive and problem gambling program. A separate State Plan for this program is developed annually and can be found at:

http://www.ddap.pa.gov/gamblingaddiction

As of July 1, 2012, DDAP, formerly under the Department of Health as the Bureau of Drug and Alcohol Programs and the Division of Drug and Alcohol Program Licensure, became a Department in its own right. This change reflects a strong commitment by the General Assembly and the Commonwealth to provide education, intervention and treatment programs to reduce the drug and alcohol abuse and dependency for all Pennsylvanians. DDAP is now capable of establishing relationships with state and community agencies at a level previously unavailable, to impact more effectively on this issue that devastates

individuals and families, destroys communities, and drives many of the costs in our state budget.

Under Act 50, DDAP is tasked with the following:

- Developing and implementing programs designed to reduce substance abuse and dependency through quality prevention, intervention, rehabilitation and treatment programs;
- Educating all Pennsylvanians on the effects and dangers drugs and alcohol abuse and dependency, and the threat they pose to public health; and,
- Mitigating the economic impact of substance abuse for the citizens of Pennsylvania.

Act 50 requires DDAP to develop a State Plan for the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of drug and alcohol abuse and dependence problems.

As acknowledged at the highest levels of government and shown by the General Assembly in creating DDAP, mitigating the devastating consequences of drug and alcohol abuse and addiction is a priority, even in challenging economic times. As policy-makers debate the merits of where to invest limited resources, the answer to their question of "*why invest in drug and alcohol programs*" is because it is cost effective - $7 return for every dollar invested, primarily in criminal justice costs.

Substance abuse and its consequences are well documented through national and state level research, multiple data sources, and countless personal stories from individuals, families and loved ones. Substance abuse directly or indirectly impacts numerous other service systems and the creation of DDAP allows for a concentrated effort at the state level to address the many issues associated with substance abuse. With the passage of Act 50 and the establishment of DDAP, coordination of efforts of agencies at the state level include the Department of Public Welfare (DPW), PA Commission on Crime and Delinquency (PCCD), PA Department of Education (PDE), PA Board of Probation and Parole (PBPP), and the Department of Corrections (DOC). DDAP also collaborates with various county and provider organizations, including the PA Community Providers Association (PCPA), PA Association of County Drug and Alcohol Administrators (PACDAA), PA Recovery Organizations-Alliance (PRO-A), and the Drug and Alcohol Services Providers Organization of Pennsylvania (DASPOP), as well as individual Single County Authorities (SCAs), treatment and prevention providers, and recovery organizations. DDAP will continue to provide guidance and technical assistance to other agencies about the prevention and treatment of substance abuse. DDAP also will continue its efforts to develop and enhance the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of drug and alcohol abuse and dependence problems.

The Need for the Department of Drug and Alcohol Programs

Substance abuse prevention, intervention, and treatment services have a profound beneficial impact on society. These services make our streets and homes safer from crime, improve our health, increase our employment (turning tax burdens into taxpayers), make us

better parents, make us safer drivers, lower the number of unwanted pregnancies, reduce our workmen's comp claims and increase our overall social functioning. At the state government level, when DDAP succeeds in its mission, other departments (e.g. DOC, DPW, DOH, DED, PennDOT, L&I, PSP) find greater success in their missions as well.

This results in extraordinary cost savings. For every additional dollar invested in addictions treatment, the taxpayer saves $7.00 in costs to society (Rand Drug Policy Research Center, 2007), **primarily in reduced criminal justice costs.**

In 2007, it was estimated that the national cost to society of **drug abuse alone**, **not including alcohol abuse**, was $193 billion (National Drug Intelligence Center [NDIC], 2011), a substantial portion of which—$61 billion—is associated with drug related crime, including criminal justice system costs and costs borne by victims of crime. If you add alcohol abuse to these figures, they increase tremendously.

> **Crime** includes three components: criminal justice system costs ($56,373,254,000), crime victim costs ($1,455,555,000), and other crime costs ($3,547,885,000). These subtotal $61,376,694,000.
>
> **Health** includes five components: specialty treatment costs ($3,723,338,000), hospital and emergency department costs for non-homicide cases ($5,684,248,000), hospital and emergency department costs for homicide cases ($12,938,000), insurance administration costs ($544,000), and other health costs ($1,995,164,000). These subtotal $11,416,232,000.
>
> **Productivity** includes seven components: labor participation costs ($49,237,777,000), specialty treatment costs for services provided at the state level ($2,828,207,000), specialty treatment costs for services provided at the federal level ($44,830,000), hospitalization costs ($287,260,000), incarceration costs ($48,121,949,000), premature mortality costs (non-homicide: $16,005,008,000), and premature mortality costs (homicide:$3,778,973,000). These subtotal $120,304,004,000.

The cost of treating drug abuse (including health costs, hospitalizations, and government specialty treatment) is estimated to be $14.6 billion, a mere 7.56% of these overall societal costs (NDIC, 2011).

Drug and alcohol treatment is cost effective in reducing use and bringing about related savings in health care. Treatment reduces the costs associated with lost productivity, crime, and incarceration across various settings and populations. The largest economic benefit of treatment is in avoided costs of crime (incarceration and victimization costs). In the California Alcohol and Drug Treatment Assessment (CALDATA) study, the cost of treating approximately 150,000 substance users was $209 million, but the savings during treatment and in the first year afterward amounted to $1.5 billion. The largest savings were related to reductions in crime. Health during and after treatment improved significantly, with corresponding reductions in use of health services.

Pennsylvania has a current population of nearly 13 million and according to the most recent (2010-2011) National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), within this population there is an estimated prevalence of 900,000 cases of substance use disorder.

The latest NSDUH survey indicates that 8% of individuals 12 years of age and older in PA have used an illicit drug in the past month. Binge drinking for individuals age 12 and older in the past month was 25%. Alcohol use for adolescents age 12-20 for the past month was at 28%. Additionally, the survey indicates that for those needing treatment, less than 10% are helped. Pennsylvania does significantly better than the rest of the nation: one out of eight in need of treatment receive it, clearly we still have far to go.

A total of $5.3 billion of Pennsylvania's state budget is spent addressing the effects of alcohol, tobacco and other drug abuse through justice, education, health, child and family assistance, mental health and developmental disabilities, public safety and state workforce programs. Pennsylvania taxpayers spend $429.59 per capita on problems from alcohol, tobacco, and other drug abuse; that is about 15.9% of the state budget; $15.13 per capita of this amount is spent on prevention, treatment, and/or research. The rest covers the burden of alcohol, tobacco, and other drug abuse on justice, education, health, child and family assistance, mental health and developmental disabilities, public safety and state workforce programs. And this is state funds only - federal and local costs are not included (National Center on Addiction and Substance Abuse, 2009).

The huge cost-benefits from treatment arise not just from decreased crime and its attendant expenses (prisons and jails, costs of time in court, etc.), but also increased employment, fewer medical expenses, reduced child protective services costs, and a number of other substantial expenses. For example, substance abuse treatment for Medicaid patients reduced total medical costs 30% in a comprehensive health maintenance organization (from $5,402 per treated member in the year prior to treatment to $3,627 in the year following treatment). The reductions were in all major areas of health care utilization (hospital stays, emergency visits and clinic visits), and did not reflect shifts in costs from one area to another. Additional funding for substance abuse services will only increase the benefits accrued for society as a whole.

These needs can be seen across a range of special populations including:

Criminal Justice: In Pennsylvania, of 51,319 total offenders in state corrections, approximately 70% or 35,923 of offenders need drug and alcohol treatment. This does not include the untold number in the county criminal justice system also in need.

Veterans: Of the approximately 995,135 Pennsylvania Veterans, an estimated 11% or 109,464 veterans have a substance abuse problem.

Pregnant Women: Of the approximately 142,370 births, in the state about 5% or 7,118 are women who are struggling with an alcohol or drug problem.

Adolescents: In Pennsylvania, an estimated 68,000 children aged 12-17 have abused drugs or alcohol in the past year.

DDAP will enhance the current substance abuse service system through a continual review of policies, procedures, and regulations that impact the delivery of prevention, intervention, and treatment services in the Commonwealth. Accountability and measurement of effectiveness of services is a standard business expectation of any publicly-funded system.

DDAP will conduct a comprehensive Needs Assessment within a year to determine as accurately as we possibly can the exact nature of substance abuse problems within the state; this information is critical to inform policy at the state level and programming at the local level. With the continuing development of research in Pennsylvania on substance abuse issues, the field will become more knowledgeable and therefore more effective.

DDAP has experienced considerable challenges in implementation of both the Performance Based Prevention System (PBPS) and the Strengthening Treatment and Recovery (STAR) Data Systems. We are working through those challenges; our expectation is that these systems will continue to become implemented, more user-friendly and, ultimately, will enhance strategic planning at both the state and county level.

The substance abuse service system in PA is entering an era of possibilities and promise. With DDAP in place, coordinated strategies will be to systematically improve the effectiveness of services provided, lower the incidence of substance abuse, and reduce the disparity that exists between need and services. This State Plan will be a continually evolving document that addresses the needs of DDAP and other state agencies, as well as the SCAs and local provider agencies. It will inform decision making and strategic planning at the state and local levels. Most importantly, this document is designed to help prevent as many Pennsylvanians as possible from becoming addicted and help those who are suffering from the disease of addiction. DDAP is committed to ensuring that quality prevention, intervention, and treatment services are provided to the citizens of our Commonwealth.

DDAP Mission and Vision

Mission

The Department of Drug and Alcohol's mission is to engage, coordinate and lead the Commonwealth of Pennsylvania's effort to prevent and reduce drug, alcohol and gambling addiction and abuse; and to promote recovery, thereby reducing the human and economic impact of the disease.

Vision

Pennsylvanians living free, or in recovery, from the disease of drug, alcohol and gambling addiction, resulting in safer, healthier, more productive and fulfilling lives.

DDAP Values

Effective Decision Making – We value decision making that is outcome-focused and quality-informed, that reflects an understanding of costs and benefits and maximizes the impact of available resources.

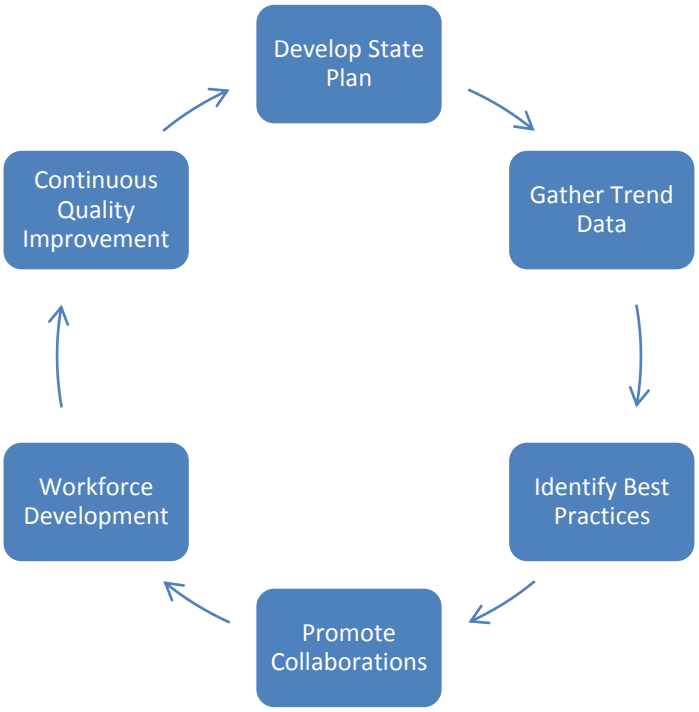
Collaboration – We value and respect the expertise and experience of stakeholders, and we reach out to develop effective partnerships with individuals and agencies across the Commonwealth that can benefit from and assist us in successfully achieving our mission.

Hope – We know that change and recovery is attainable yielding life changing benefits for individuals, family members and communities through their commitment to prevent and achieve freedom and recovery from addiction.

Ethics – We do the right thing for the right reasons, demonstrating integrity in every action that we take, including doing no harm.

Diversity – We value diversity in the workforce – including diversity in gender, age, race, religion, sexual orientation, recovery and other related experiences – so that it reflects the various strengths and gives a voice to the needs of the diverse communities we serve.

DDAP Goals and State Plan 2013-2014



Goal #1 - Develop state plans for substance use disorders and problem gambling.

Goal #2 - Gather and analyze trending data in order to maximize the effectiveness of our efforts in prevention, intervention, treatment and recovery.

Goal #3 - To identify and promote best practices and policies to ensure full access to high quality and cost effective prevention, intervention, treatment and recovery support services.

Goal #4 - Increase Pennsylvania's effectiveness of its drug, alcohol, and gambling prevention and treatment efforts by promoting and establishing federal, state and local collaboration.

Goal #5 - Develop and maintain a highly competent and efficient workforce and infrastructure to ensure the Department can accomplish its mission and achieve its goals.

Goal #6 - Ensure a system of continuous quality improvement (CQI).

Objectives associated with each of these major goals are listed below. Detailed progress for these priorities will be explained later in the plan document. This is a robust and ambitious plan, targeting the needs of the Commonwealth and its citizens.

1. Develop state plans for substance use disorders and problem gambling.

a. Create a state plan that responds to needs assessment data using Act 50 as the framework.
b. Ensure that cost benefit analysis is present in the plan structure for all appropriate plan elements.
c. Gather input from expert opinion, research and community stakeholders.
d. Create a project plan for the state plan, including a timeline for milestones.
e. Analyze SCA documents for aspects that may be incorporated into the state plan.
f. Establish plan guidelines for the SCAs to use in development of their local plans that is consistent with state plan priorities

2. Gather and analyze trending data in order to maximize the effectiveness of our efforts in prevention, intervention, treatment, and recovery.

a. Ensure the coordination of research on drug and alcohol abuse and dependence (see p. 71, Act 50 of 2010 Section 2301-A, 1(vii)).
    i. Establish needs assessment framework, including baseline data sets by October 2013.
    ii. Organize data for review and analysis by field experts, stakeholders and others.
b. Improve prevention outcomes through data-driven management (see p. 40).
    i. Establish processes for routine updating of data sets to include state and county level indicators.
        1. Update reporting requirements for SCAs and providers.
        2. Monitor reporting of prevention services in PBPS and treatment services in STAR (see p. 73).

ii. Establish guidelines for completion of local needs assessments by SCAs, including identification of consistencies and differences with state level data.
iii. Continue to identify and obtain data sets to be used in assessing need, including collaboration with other state agencies that have information related to drug and alcohol problems, as well as their prevention and treatment.
iv. Work with SCAs and providers to identify enhancements or changes needed to PBPS and STAR data systems.
v. Communicate findings to SCAs, prevention providers and the general public.

3. To identify and promote best practices and policies to ensure full access to high quality and cost effective prevention, intervention, treatment, and recovery services.

a. Special Populations (Note: While other populations are addressed, priority is emphasized with these populations due to prevalence, legislative support, harm associated, as well as cost related issues.)
    i. Substance of abuse:
        1. Prescription drugs: Increase statewide awareness and prevent the misuse/abuse of prescription drugs (see p. 39).
            a. Overdose Prevention:
                i. Develop overdose prevention resources for use in community, prevention, and treatment settings.
                ii. Continue to work collaboratively with The Statewide Injury Prevention and Control Plan Injury Community Planning Group (ICPG) to prevent prescription drug injury and incidents.
            b. Prevention:
                i. Identify effective programs for prevention of prescription drug misuse/abuse/addiction.
                ii. Develop and implement strategy to increase use of these programs.
                iii. Monitor adoption of these effective programs through PBPS data reporting.
                iv. Maintain data on the prevalence of prescription drug misuse/abuse/addiction as well as attitudes about use at the national, state and local level.
                v. Develop and maintain up to date fact sheet on prescription drug misuse/abuse/addiction and consequences.
                vi. Expand prescription drug disposal availability.
                vii. Support state and national efforts on prescription drug monitoring programs and tamper resistant medications.
                viii. Physician training (see Goal 3.a.i.2 above).
            c. Treatment:

i. Seek resources to expand treatment availability.
ii. Identify primary populations in need of treatment and best practice models for responding.
iii. Identify and disseminate best practices via Methadone Death and Incident Review Team to respond to dangerous drug interactions with methadone.

2. Marijuana: Increase statewide awareness and prevent the use of marijuana (see p. 48).
    a. Identify effective programs for prevention of marijuana use.
    b. Develop and implement strategy to increase use of these programs.
    c. Monitor adoption of these effective programs through PBPS data reporting.
    d. Maintain data on the prevalence of marijuana use as well as attitudes about use at the national, state, and local level.
    e. Develop and maintain up to date fact sheet on marijuana use and consequences.

ii. Demographic
1. Adolescence/Underage Drinking: Increase the statewide awareness and reduce the incidence of underage drinking, as well as drinking and driving (see p. 36).
    a. Identify effective programs for prevention of underage drinking.
    b. Develop and implement strategy to increase use of these programs.
    c. Monitor adoption of these effective programs through PBPS data reporting.
    d. Maintain data on the prevalence of underage drinking and its consequences at the national, state, and local level.
    e. Work in partnership with other agencies and other state efforts to prevent underage drinking.
    f. Continue to work on statewide multiagency safety team to implement comprehensive strategic highway safety improvement plan.
2. Pregnant/Women with Children: Increase access to care in a way that reduces burden to foster care system (see p. 79).

a. Work with the Office of Children, Youth and Families to maximize women and children's program resources as a means of diverting children from foster care.
b. Decrease the risk of addicted babies or fetal alcohol affected babies by increasing use of women and children's programs for pregnant women in need of residential drug and alcohol treatment.
c. Implement and evaluate FASD State Plan.
d. Develop and implement programming during FASD Awareness Month to raise awareness of FASD prevention and consequence.
e. Develop and maintain training and educational resources, including those focused on relevant healthcare providers.

3. Older Adults: Seek coordination of efforts to deal with the problems including those relating to senior citizens and social security (see p. 67).
    a. Collaborate with Department of Aging and Pennsylvania Behavioral Health and Aging Coalition to assess the drug and alcohol prevention and treatment needs of older adults.
    b. Monitor national, state, and local trends for the needs of older adults.
    c. Promote programs which educate older adults of issues related to the incorrect use of prescribed and over-the-counter medications.

iii. Medical complications

1. Hepatitis C: Provide screening, testing, referral, and case management services for individuals at risk for hepatitis C (see p. 61).
    a. Continue to collaborate with the Department of Health, Bureau of Epidemiology, on best practices with this population.
    b. Continue to host annual meetings of Hepatitis C initiative including physicians, pharmaceutical companies, and SCAs to examine emerging trends in management of Hepatitis C.
    c. Promote public awareness on the impact of Hepatitis C and availability of testing.

2. Medical practice: Cooperate with organized medicine to disseminate medical guidelines for the use of drugs and controlled substances in medical practice (see p. 71, Act 50 of 2010 Section 2301-A, 1(vi)).
    a. Work with the medical community to develop a training regarding responsible prescribing of drugs of abuse to be completed by June 30, 2014.
    b. Develop and implement plan for expansion of SBIRT services.
    c. Utilize findings from Methadone Death and Incident Review Team to establish best practices for use of methadone and disseminate as appropriate to addiction treatment and medical community.
    d. Encourage use of tamper resistant opioids.
3. FASD: Develop and implement a statewide plan to address Fetal Alcohol Spectrum Disorders (FASD)(see p. 51).

b. Informed Best Practices:
    i. System of Care: Maintain a Recovery-Oriented Systems of Care (ROSC) within the Commonwealth that supports a recovery management model through coordinated networks of community-based services and supports that are person-centered and strength-based (see p. 59).
        1. Develop and implement strategy for the provision of a comprehensive continuum of care that supports individuals and families from prevention and outreach to initial access through support for sustained recovery.
        2. Identify and strengthen use of natural community based recovery management and support resources.
        3. Increase professional staff understanding and use of exiting and future community based recovery supports.
        4. Seek and utilize feedback from individuals in recovery in strategy development and implementation.
    ii. Prevention: Continue to support SCAs in the development and evaluation of innovative prevention programs. Those programs showing success will be recommended to the Service to Science national initiative supported and spearheaded by SAMHSA/CSAP, with the goal of helping the program move toward becoming an evidence-based program.

c. Information Based on Expert Collaboration: The formation of local agencies and local coordinating councils, promotion of cooperation and coordination among such groups, encouragement of communication of ideas, and recommendations from such groups to the Pennsylvania

Advisory Council on Drug and Alcohol Abuse (see p. 70, Act 50 of 2010 Section 2301-A, 1(iii)).

i. Clinical Standards:
    1. Maintain the Clinical Standards Committee (CSC) to make recommendations to DDAP regarding best practices for the identification, assessment, placement and treatment of alcohol and other drug problems (see p. 64).
    2. CSC to complete update of the Pennsylvania Client Placement Criteria (PCPC) and testing of the update by December 2013.

ii. Curriculum: Enhance the development of a model curriculum that utilizes pertinent data and information that improves substance abuse prevention (see p. 49, Act 50 of 2010 Section 2301-A, 1(xi)).
    1. Identify evidence based curriculum for different populations served.
    2. Develop and implement strategy, including the development of tool kits as appropriate, to increase use of these curriculums in school and community settings.
    3. Collaborate with the Pennsylvania Commission on Crime and Delinquency and the Department of Education in program identification and strategy development.
    4. Develop plan to strengthen fidelity to program design and monitor fidelity and adaptations.
    5. Develop and implement evaluation strategy for funded programs.

d. Development/Implementation of Standards
    i. Local Government: Development of model drug and alcohol abuse and dependence control plans for local government, utilizing the concepts incorporated in the State Plan (Act 50 of 2010 Section 2301-A, 1(iv)) (see p. 71).
        1. Continue to contract with Single County Authorities for the provision of local needs assessments, plans, and service provision and management.
        2. Identify high need areas based on data analysis and pursue strategies and resources for local responses.
        3. Review availability of service continuum within local resources and develop strategies to provide services not available within local programming.
    ii. Treatment Facilities: In collaboration with treatment providers and other stakeholders, identify and initiate regulatory change needed

to reduce unneeded administrative burden, promote best practices, and ensure health and safety (see p. 85).

iii. Contracting: To continue to provide grants and contracts to local governments and public and private agencies, institutions and organizations for the prevention, intervention, treatment, rehabilitation, research, education and training aspects of drug and alcohol dependence (see p. 86, Act 50 of 2010 Section 2301-A, 1(xix)).

iv. Detection methods: Investigate methods for more precise detection and determination of alcohol and controlled substances in urine and blood samples, and by other means; and publish the current basis of uniform methodology for such detections and determinations (see p. 72, Act 50 of 2010 Section 2301-A, 1(viii)).
    1. Meet with the Department of Health, Bureau of Laboratories to further review and revise testing methodology, as needed.
    2. Utilize Listserves, Policy Bulletins, Informational Bulletins, and DDAP's website to publicize best practice in detecting controlled substances and testing methods.
    3. Consult with the Clinical Standards Committee, as appropriate, to help disseminate this information. Training will continue to be offered on the synthetic drug use.

v. Intervention:
    1. Assess current intervention services identifying strengths, gaps, and outcomes.
    2. Identify best practices for intervention and develop plan to increase their use.
    3. Work with other stakeholders including Department of Education, Department of Public Welfare Office of Mental Health and Substance Abuse Services and practitioners to strengthen Student Assistance Services.

4. Increase Pennsylvania's effectiveness of its drug, alcohol and gambling prevention and treatment efforts by promoting and establishing federal, state and local collaboration.

a. Law enforcement collaborations

i. Criminal offenders: Development of treatment and rehabilitation services for male and female juveniles and adults who are charged with, convicted of or serving a criminal sentence for any criminal offense of this Commonwealth (see p. 56, Act 50 of 2010 Section 2301-A, 1(xv)).

1. DDAP will develop and provide a cross-system training in partnership with probations and parole representatives designed to maximize the resources of both systems by developing an understanding of how to add value to each other's roles. The training will be delivered to a minimum of 200 individuals by June 30, 2014.
2. DDAP will support PCCD in the development of performance measures for the individuals diverted from incarceration through the restrictive intermediate punishment program.
3. Evaluate county based MA pilot projects and determine feasibility for expansion.

ii. Crime prevention: Coordination of all health and rehabilitation efforts to deal with the problem of drug and alcohol abuse and dependence, including, those relating to law enforcement assistance, highway safety, parole and probation systems (see p. 68, Act 50 of 2010 Section 2301-A, 1(ii)).

1. Implement collaborative pilot project with DPW, DOC, and PBPP to assess inmates drug and alcohol needs while in transition units and have medical assistance application completed pre-release so those individuals eligible for MA have Health Choices coverage available for needed treatment services upon release.
2. Continue to provide information and technical assistance to other agencies as requested.

iii. Emergency assistance: (see Act 50 of 2010 Section 2301-A, 1(xvii))

1. Continue to support the availability of medically monitored and medically managed detoxification.

2. Maintain requirement that individuals in need of SCA funded detoxification be admitted within 24 hours of identification.

iv. Identify overlap with other agencies including, but not limited to the areas of impact from drug and alcohol problems and/or policy, program, oversight, and workforce in health, mental health, education and Commonwealth employees. (Act 50 of 2010 Section 2301-A, 1(vii))

1. Develop and implement strategies to avoid duplicative efforts and/or add value.
2. Collaborate as appropriate on the development of programs, policies and training.
3. Continue to partner with PCCD, OCYF, OMHSAS, PBPP, DOC, the Juvenile Court Judges Commission and others, to ensure that the most cost effective, efficient services are provided for the prevention and treatment of drug and alcohol problems.
4. Explore opportunities to meet with various employee unions and the Civil Service Commission and collaborate on issues surrounding substance abuse.

b. Encourage collaborations between stakeholders: Develop community-based drug or alcohol abuse treatment services in a cooperative manner among State and local governmental agencies and departments and public and private agencies, institutions and organizations (see p. 56, Act 50 of 2010 Section 2301-A, 1(xvi)).

i. Parent Panel: Maintain a panel of parents to study family and community access to alcohol and drug abuse information, intervention and treatment services and make recommendations (see p. 57).

1. Support Parent Panel initiative to increase physician and emergency department staff knowledge and sensitivity regarding drug and alcohol problems.

ii. Pennsylvania Association of County Drug and Alcohol Administrators

1. DDAP senior management staff will continue to regularly respond to invitations to participate in PACDAA meetings.
2. PACDAA representation and/or input will be sought in the development of policy and best practices for drug and alcohol services.

iii. Provider Associations:

1. Representation and/or input will be sought from relevant provider organizations in the development of policies

and/or best practices for drug and alcohol. These organizations include, but are not limited to:

a. Commonwealth Prevention Alliance
b. Drug and Alcohol Service Providers of PA
c. Pennsylvania Community Providers Association
d. Pennsylvania Prevention Directors Association

iv. Individuals in Recovery

1. Continue to support the work of the Pennsylvania Recovery Organization Alliance in the development and provision of recovery focused training, as well as the development of recovery informed practices and policies.
2. Representation and/or input will be sought from individuals in recovery through the recovery organizations in the development of policies and/or best practices for drug and alcohol.

v. Education/Research: Look for opportunities to reach out to universities and research institutes (where most studies are conducted) to discuss how best to coordinate activities related to research and studies. DDAP will attempt to develop working relationships with these universities and institutes.

1. Maintain the oversight of the clinical guidelines (PCPC and the ASAM) used as placement tools for state/federally funded treatment.

5. Develop and maintain a highly competent and efficient workforce and infrastructure to ensure the Department can accomplish its mission and achieve its goals.

a. Establish and maintain effective and relevant training for individuals working in the drug and alcohol field. (Act 50 of 2010 Section 2301-A, 1(xiv))
    1) Assess current training needs and resources: Work to address those identified needs through collaboration with other state and local resources. DDAP plans to identify potential trainings that are skill/competency based, provide expert level information/skills, measure learning and are sustainable.
    2) Professional Training: Facilitate training programs for professional and nonprofessional personnel with respect to drug and alcohol abuse and dependence, including the encouragement of such programs by local governments (see p. 72).
        i. Continue to provide training through mini-regionals, regional training institutes, and on-site traings.
        ii. Collaborate with the Northeast Center for Application of Prevention Technologies and the Addiction Technology Transfer Center to incorporate competency based trainings for the prevention and treatment workforce and internal staff development.
        iii. Implement on line video based trainings for prevention.
    3) Stakeholder Training: To offer educational courses for law enforcement officials, including prosecuting attorneys, court personnel, the judiciary, probation and parole officers, correctional officers and other law enforcement personnel, welfare, vocational rehabilitation and other State and local officials who come in contact with drug abuse and dependence problems (Act 50 of 2010 Section 2301-A, 1(xiii)) (see p. 57).
    4) Staff development :
        i. Establish evaluation method for trainings and include benchmarks in the DDAP CQI plan.
        ii. Identify training needs for internal staff development, as well as educational opportunities that will foster learning/growth at an expert level.
    5) Develop Recommendations: Identify and implement realistic recommendations to positively impact workforce issues within the Commonwealth (see p. 47).

6. Establish a system of continuous quality improvement (CQI).

a. Licensure: Maintain licensing process that ensures good standards of practice and protects health and safety.
    i. Continue review and identification of needed changes to licensing regulations.
    ii. Ensure consistency of application of standards by all Licensing Specialists.
    iii. Support development of best practices for program, health and safety by providers.
    iv. Redesign the licensing and tracking business process.
b. Contracted Services: Develop and implement quality assurance assessment process for SCA and provider contracted services that assesses compliance with required standards and includes performance measures.
    i. Work with relevant Bureaus and stakeholders, including PACDAA, providers, community partners, families and individuals in recovery in the development of performance measures for Department and SCA contracts, including use of PBPS and STAR data elements.
    ii. Maintain annual SCA monitoring.
c. Department
    i. Develop Department Continuous Quality Assurance Plan by January 2014.
    ii. Each Bureau will collaborate to have an overall established CQI plan.

Chapter 2:

Annual Report 2011-12
Progress Report 2012-13

This chapter reviews progress made on goals/priorities established by the Bureau of Drug and Alcohol Programs in the 2012-13 State Plan that was developed while in the Department of Health. Progress Reports for these goals/priorities for FY 2011/12 and 2012/13 are included. This chapter also contains additional information on goals and objectives included in our FY 2013/14 Plan, as well as new areas of interest since the implementation of Act 50 of 2010.

PREVENTION

The Department of Drug and Alcohol Programs, Bureau of Treatment, Prevention and Intervention, Division of Prevention and Intervention (Division), is responsible for the development, oversight and management of substance abuse prevention and intervention services throughout Pennsylvania. The Division of Prevention and Intervention strives to increase the implementation of prevention programs, age-appropriate strategies, policies and practices that are based on research proving effectiveness and/or best practices within the substance abuse field. The system oversight, management of data and the evaluation of services is supported by the nationally recognized Performance-Based Prevention System (PBPS) software. The major focus is to reduce risk factors associated with substance use, and to promote the development of healthy lifestyles that positively impact individuals across the lifespan, in their communities, families and schools.

DDAP funds these efforts through grant agreements with Single County Authorities (SCAs) throughout the Commonwealth. SCAs are required to utilize all six Federal Strategies and the Institute of Medicine (IOM) Prevention Classifications within the Strategic Prevention Framework model to ensure the delivery of single and recurring prevention services. All SCA-funded prevention services must be outlined in the SCA's County Comprehensive Strategic Plan, including the funding sources used to support the program services. All SCA-funded prevention services must be reported in PBPS, regardless of the funding source. Those entities funding or delivering drug and alcohol prevention services work with their local SCA to assure that their prevention activities fit the local strategic plan. All data collected on these services is reported to the local SCA and DDAP. The data reported must incorporate the data elements collected in the PBPS.

SIX FEDERAL STRATEGIES

The six (6) Federal Strategies, based in the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs, are defined as:

Information Dissemination - provides awareness and knowledge on the nature and extent of alcohol, tobacco and drug use, abuse and addiction and the effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Some examples of services captured under the Information Dissemination Strategy include: media campaigns, health promotions and newsletters.

Education - involves two-way communication, which is distinguished from the Information Dissemination category by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this category are to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities. Some examples of programs that are captured under the Education Strategy include: Celebrating Families, Girl Power and Life

Skills Training.

Alternative Activities - operates under the premise that healthy activities will deter participants from the use of alcohol, tobacco and other drugs (ATOD). The premise is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by ATOD, and would, therefore, minimize or eliminate use of ATOD. These activities must be directly linked to an educational or skill-building activity. Some examples of programs captured under the Alternative Activities Strategy include: youth/peer mentoring programs, Nurse Family Partnership and Big Brother/Big Sister.

Problem Identification and Referral - targets those persons who have experienced first use of illicit/age-inappropriate use of tobacco and those individuals who have indulged in the first use of illicit drugs and alcohol. This helps to assess if the behavior of such individuals can be reversed through education. Some examples of services/programs captured under the Problem Identification and Referral Strategy include: SAP Core Team Meetings, DUI/DWI Programs and Employee Assistance Programs.

Community-Based Process - aims directly at building community capacity to enhance the ability of communities to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services, inter-agency collaboration, coalition building and networking. Some examples of services captured under the Community-Based Process Strategy include: technical assistance, multi-agency coordination and collaboration and assessing community needs.

Environmental - establishes or changes written and unwritten community standards, codes, ordinances and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs. This category is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to action-oriented initiatives. Some examples of services captured under the Environmental Strategy include: counter-advertising printed materials, social norms marketing and changing policies.

INSTITUTE OF MEDICINE (IOM) PREVENTION CLASSIFICATIONS

Defined below are the three (3) IOM Prevention Classifications that can contain the six (6) major federal strategies. Included are examples of activities that comprise the overall concept of services that prevent or reduce the use and abuse of ATOD:

- Universal Preventive Interventions – activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

- Selective Preventive Interventions – activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

- Indicated Preventive Interventions – activities targeted to individuals in high-risk environments identified as having minimal but detectable signs or symptoms foreshadowing a disorder or having biological markers indicating predisposition for a disorder which does not yet meet diagnostic levels.

STRATEGIC PREVENTION FRAMEWORK (SPF) MODEL

SCAs must ensure that all five steps of SPF are adhered to in the implementation of performance-based prevention: Needs Assessment, Capacity, Planning, Implementation and Evaluation. Cultural competency and sustainability must also be considered throughout all five (5) steps of the SPF model.

- Needs Assessment - The needs assessment is designed to profile population needs, resources and readiness to address needs and gaps. The process involves the collection and analysis of data to define problems within a geographic area. Assessing resources includes identifying service gaps, assessing cultural competence and identifying the existing prevention infrastructure in the county and/or community. It also involves assessing readiness and leadership to implement programs, strategies, policies and practices.

- The SCAs, as well as those funding or delivering drug and alcohol prevention services, must use a data-driven decision-making process to determine which risk and protective factors will be utilized to create a "Comprehensive Strategic Plan." Structured and relevant programs, strategies, policies and practices are essential to successfully reduce risk and enhance protective factors in specific targeted populations and geographic areas. The Needs Assessment must be the process utilized to identify risk and protective factors.

Capacity – The must increase efforts to mobilize and/or build capacity to address needs. Building capacity involves the mobilization of resources within a community. A key aspect of capacity building is convening key stakeholders, coalitions and service providers to plan and implement sustainable prevention efforts during the planning and implementation phase. The mobilization of resources includes financial and organizational resources, as well as the creation of partnerships. Readiness, cultural competence and leadership capacity are addressed and strengthened through education and systems thinking. Additionally, capacity building should include a focus on sustainability, as well as an evaluation of capacity.

Planning – Planning involves the creation and development of a plan that includes implementing programs, strategies, policies and practices that create a logical, data-driven plan that reduces the risk factors and enhances the protective factors that contribute to substance abuse in a specific county/community. The planning process produces strategic county-wide and community targeted goals, as well as logic models and preliminary action plans. In addition, it also involves the identification and selection of evidence-based strategies that include changes in programs, strategies, policies and practices that will reduce substance abuse. Even though one community may show similar alcohol-related issues, the

underlying factors that contribute most to them will vary between communities. If the programs, strategies, policies and practices do not address the underlying risk and protective factors that contribute to the problem, then the intervention is unlikely to be effective in changing the substance abuse problem or behavior.

Implementation – SCAs are required to implement and provide ongoing monitoring of their Comprehensive Strategic Plan. This includes, but is not limited to, the collection of process measure data, performance targets and the fidelity of implementation. Any modifications and changes that are made to the original programs must be documented throughout the implementation of the program, utilizing the developer's program fidelity/adaptation instrument and reported in the SCA's Annual Outcome Evaluation Report. This is to determine whether or not expected outcomes have been attained as a result of adaptations made to programs.

Evaluation – The SCAs must evaluate their Comprehensive Strategic Plan. The SCAs must measure the impact of the implemented programs, strategies, policies, practices and identify areas for improvement.

PROGRAMS AND STRATEGIES

DDAP encourages SCAs and prevention providers throughout the Commonwealth to utilize Evidence-Based and State Approved Programs as a part of their comprehensive approach within their counties. Each SCA is required to deliver at least 25% of services through a combination of Evidence-Based and State Approved Programs.

Using a combination of Evidence-Based and State Approved Programs and Strategies, based on local community needs, has proven to be a highly successful and effective way of reducing risk factors associated with substance use/abuse. SCAs plan and deliver program services by considering and addressing underage drinking risk and protective factors, youth attitudes towards use, youth-perceived risk concerning consumption and by tracking social indicator data.

Evidence-Based, State Approved Programs and State Effective Strategies are defined as follows:

Evidence-Based Programs include strategies, activities, approaches and programs which are:

- Shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse.
- Grounded in a clear theoretical foundation and have been carefully implemented.
- Reviewed by other researchers to ensure that proper evaluation findings exist.

- Replicated and have produced desired results in a variety of settings.

State Approved Programs meet the following minimum criteria:

- Program/principle has been identified or recognized publicly and has received awards, honors or mentions.
- Program/principle has appeared in a non-refereed professional publication or journal. Note: It is important to distinguish between citations found in professional publications and those found in journals.
- Program/principle must have an evaluation that includes, but is not limited to, a pre/post-test and/or survey.

State Approved Effective Strategies are defined as programs which:

- Capture activities that utilize methods of best practice.
- Provide basic ATOD awareness/education, as well as everyday alternative prevention activities.
- Captures strategies that address population-level change.
- Captures activities necessary to implement or enhance evidence-based and state approved programs.

Each of the three program categories listed above must be delivered through single services and/or recurring services types and be recorded as such in the data base. SCAs are required to provide 20% of services through recurring events. Single and Recurring Services are defined as follows:

- Single Service Type – Single prevention services are one-time activities intended to inform general and specific populations about substance use or abuse (examples: Health Fairs, Speaking Engagements).
- Recurring Service Type – Recurring prevention services are a pre-planned series of structured program lessons and/or activities. These types of services are intended to inform, educate, develop skills and identify/refer individuals who may be at risk for substance use or abuse. A recurring prevention activity needs to have an anticipated measurable outcome, including, but not limited to, Pre/Post Test (examples: Classroom Education, Peer Leadership Programs, Peer Mentoring, and ATOD Free Activities Recurring).

There are approximately 55 evidence-based and 51 State Approved Programs that are currently being delivered throughout the Commonwealth that address drug use. Some of these programs include, but are not limited to:

- Too Good For Drugs – a school-based prevention program designed to reduce the intention to use alcohol, tobacco and illegal drugs in middle and high school students;
- Students Against Destruction Decisions (SADD) – a student-run program for addressing substance abuse issue within local schools;
- Girls Circle – a structured support group for girls that is designed to increase positive connection, personal and collective strengths and competencies;
- Life Skills Training – a school-based program that works with elementary to high school students to assist them in developing the necessary skills to resist social pressures to use alcohol, tobacco and other drugs;
- Families That Care – Guiding Good Choices – a program for parents;
- Communities Mobilizing for Change on Alcohol (CMCA) – a community-organizing program designed to reduce adolescent access to alcohol by changing community policies and practices;
- Student Assistance Program (SAP) – a mandatory intervention program provided within the school setting intended to identify and address problems negatively impacting student academic and social growth; and,
- Project Lead and Seed – a structured leadership program in which adults, such as parents, youth pastors, youth-serving civic organization facilitators or teachers are trained to return to their schools or communities to provide training to their own youth leaders (in middle or high school) who implement action plans to reduce and prevent underage drinking tobacco and other drugs.

DDAP also collaborates with and supports other state agencies and organizations in their efforts to reduce substance use/abuse and promote health and rehabilitation efforts.

- Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services (OMHSAS)
    - Pennsylvania Youth Suicide Prevention Monitoring Committee – The Pennsylvania Youth Suicide Prevention initiative is a multi-system collaboration to reduce youth suicide.
- Substance Abuse and Mental Health Services Administration (SAMHSA)
    - Support SAMHSA prevention initiatives such as the National Town Hall Meetings program and Sober Truth on Preventing Underage Drinking Act Grants.
- Pennsylvania DUI Association
    - Students Against Destructive Decisions (S.A.D.D.)
    - Pennsylvania Driving Under the Influence Association Conference
- Pennsylvania Liquor Control Board (PLCB)
    - Contribute to the mandated Act 85 Legislative Report coordinated by the Pennsylvania Liquor Control Board.
- Pennsylvania Commission on Crime and Delinquency (PCCD)

- Disproportionate Minority Contact Committee – Provides technical assistance and information to ensure that individual communities are providing the necessary drug and alcohol prevention supports to disproportionate minorities.
- Balanced and Restorative Justice in Pennsylvania Committee – The committee supports the juvenile justice system in working with children that have committed delinquent acts and supports their care and rehabilitation to include, but not limited to substance abuse issues.

- Pennsylvania Department of Health
  - Statewide Injury Prevention & Control Plan Injury Community Planning Group (ICPG) – Falls Prevention in Older Adults Committee –Mission is to develop a comprehensive and coordinated plan that focuses on preventing injuries and violence across the lifespan by empowering state and local partners through the collection and analysis of data and the leveraging of resources for injury prevention programs to recapture lost human potential. Workgroups have been formed for three main injury topics: motor vehicle crashes, unintentional falls and unintentional poisonings.
  - Sexual Violence Primary Prevention Planning Committee – Addresses sexual violence prevention throughout the state of Pennsylvania.
  - Pennsylvania Coalition Against Domestic Violence – Assist in the development of a statewide prevention plan to support communities throughout Pennsylvania to prevent domestic violence before it occurs.
  - Pennsylvania Department of Education.
  - Pennsylvania School Wide Positive Behavior Support State Leadership Team - Through training and technical assistance, supports schools and their family and community partners to create and sustain comprehensive school based behavioral health support systems in order to promote the academic, social and emotional well-being of all Pennsylvania's students.
  - Youth and Family Training Institute Advisory Board - To achieve quality family and youth driven outcomes by advancing the philosophy, practices and principles of High Fidelity Wraparound through training, coaching, credentialing and ensuring fidelity to the process.
  - Safe and Supportive Schools (SAS) Student Interpersonal Skills Development Committee - To develop social and emotional standards that educators and teachers will utilize for instructions with students Pre-K to 12.
  - Student Assistance Program Commonwealth Interagency Committee – Provides leadership for developing a safe and drug-free environment and mental health wellness in schools and communities across the Commonwealth.
- Pennsylvania Department of Transportation

    - Multi Agency Safety Team (MAST) – Assist in the development and implementation of the Comprehensive Strategic Highway Safety Improvement Plan.
    - PennDOT Safety Advisory Committee (SAC) – Assist with determining funding obligations which are planned and proportioned based on availability of funds, ability to accomplish identified countermeasures, and effectiveness of programming to reduce fatalities.
    - PennDOT Strategic Highway Safety Plan (SHSP) Steering Committee – Assist in the development of a comprehensive, data-driven strategic plan that includes goals and strategies to substantially reduce traffic related fatalities and major injuries.
- Commonwealth Prevention Alliance (CPA)
    - Representative to the Board of Directors
    - Conference Planning Committee – Provide trainers and staff support for the annual conference.
- Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA**)**
    - Provides information and support to stakeholders to include review of grants.
    - Pennsylvania Prevention Director's Association (PPDA).
    - Provides information and support to stakeholders to include review of grants.
- Drug Free Pennsylvania
    - Develops and disseminates media literacy curriculums for middle and high school students. Provides training on the curriculums. Coordinates with the Department and the National Guard for an annual Public Service Announcement Contest in schools across the Commonwealth.

PREVENTION

ANNUAL REPORT FY 2011-12, PROGRESS REPORT FY 2012-13

DDAP has determined several key issues as priorities in the drive to prevent alcohol, tobacco and other drug use. Each priority was chosen as a need to address based on local, state and national initiatives. DDAP priorities include:

- Increase the statewide awareness and reduce the incidence of underage drinking, underage drinking and driving and drinking and driving.
- Increase statewide awareness and prevent the misuse/abuse of prescription drugs and drug overdose.
- Improve prevention outcomes through data-driven management.
- Enhance the Pennsylvania prevention system capacity.
- Identify and implement realistic recommendations to positively impact workforce issues within the Commonwealth.
- Increase statewide awareness and prevent the use of marijuana.
- Enhance the development of a model curriculum that utilizes pertinent data and information that improves substance abuse prevention.

PAST AND CONTINUING PRIORITY: Increase the statewide awareness and reduce the incidence of underage drinking, underage drinking and driving, and drinking and driving.

Background: DDAP recognized the need to increase awareness of alcohol related incidents based on local, state and national data and initiatives. According to the Administrative Office of Pennsylvania Courts (APOC), there was a 7% increase in adult offenses for driving under the influence between 2009 and 2010. There was a 16% increase in youth offenses for driving under the influence and a 9% increase in underage drinking offenses between the years 2009 and 2010. National Outcome Measure (NOMS) survey data collected for the past 5 years shows that alcohol is the substance most commonly reported to have ever been used by youth respondents. For FY 2011/2012, 32.6% of youth respondents reported ever drinking alcohol. Among just those respondents who were age 15-17, the percentage of those having ever used is 60%. According to the Pennsylvania Department of Transportation, alcohol-related crashes were 4.7 times more likely to result in death than those not related to alcohol.

BDAP assisted the SAMHSA in supporting national initiatives on underage drinking. BDAP worked collaboratively with the SAMHSA to assist in the development, implementation and monitoring of the National Town Hall Meetings Program, which provides public education and awareness on underage drinking in the Commonwealth. BDAP coordinated and oversaw the county projects, provided technical assistance to county teams, and coordinated funding for various projects associated with underage drinking.

The Strategic Prevention Framework State Incentive Grant (SPF SIG) was a five-year grant from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (CSAP). BDAP was awarded this $10,465,000 grant in October 2006 and the funding came to an end in September 2012. The purpose of SPF SIG was to enable qualified applicants to design and implement accessible, efficient and integrated alcohol prevention services throughout the Commonwealth. As required by SAMHSA/ CSAP, the Pennsylvania State Epidemiological Outcomes Workgroup (SEOW) examined data on alcohol, tobacco and other illicit drug consumption and its consequences, and compiled "The Pennsylvania State Epidemiological Profile." Based on the profile, the priorities chosen were:

Focus: Reducing alcohol use and related problems among persons 11 through 21 years of age:

- To prevent (reduce) the early initiation and regular use of alcohol in middle and high school;
- To prevent (reduce) drinking and driving among persons ages 16 through 21;
- To reduce the illegal use and misuse of alcohol among persons ages 18 through 21.

The SPF SIG underage drinking priorities gave the 17 grantees the opportunity to address underage drinking through a variety of evidence-based programs and environmental programs and strategies. The grantees implemented community plans which outlined:

- The data-driven processes from which priority risk factors for the chosen priority emerged;
- Activities involved in mobilizing and building the capacity of the grantee and the community;
- The planning process through which specific evidence-based intervention strategies were identified that the grantee used to address priorities, including a logic model; and,
- A work plan for implementing selected strategies, including how the grantee would conduct SPF efforts in both a sustainable and culturally competent manner.

The 17 SPF SIG grantees provided 3,054 services in fiscal year 2011-12. Through these activities they served a total of 27,650 individuals (23,496 single service attendees and 4,154 recurring service participants). Programs and strategies implemented by SPF SIG

grantees included Communities Mobilizing for Change on Alcohol, Too Good for Drugs, Class Action, Brief Alcohol Screening and Intervention for College Students and Social Norms Campaigns. Data shows we reached 426,623 people through information dissemination, public campaigns to include radio and television spots, and policy/practice change.

BDAP participated in the statewide Multi Agency Safety Team (MAST), which is tasked with the development and implementation of the Comprehensive Strategic Highway Safety Improvement Plan. In addition to other highway safety issues, this group focuses on underage drinking and driving. BDAP provided the following data collected in PBPS to the MAST for their annual report: number of people receiving alcohol related education, and the results from the annual youth and adult National Outcome Measure surveys administered to those receiving prevention services for the question – During the past 12 months, have you driven a vehicle while you were under the influence of alcohol only?

BDAP worked with the DUI Association in the planning of their annual conference.

National Guard services were provided statewide as a result of a Memorandum of Understanding between the Department of Health and the Pennsylvania National Guard Drug Demand Reduction Division.

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DDAP continues to assist the SAMHSA in supporting national initiatives on underage drinking through distribution of list serves and informational resources. When requested, DDAP will provide the SAMHSA with community contacts regarding the National Town Hall Meetings Program.

DDAP completed the final evaluation for the SPF-SIG grant in September of 2012. A total of 96 programs were assessed during the five year period. The grantees expressed a common accomplishment of strengthening local networks/coalitions/partnerships to address underage drinking and drinking and driving.

Community outcome measures are indirectly related to the targeted SPF SIG priorities that were established at the beginning of the project as initial and secondary indicators of alcohol and alcohol-related problems. These outcome measures indicate the following changes:

1. A small reduction in arrest rates for alcohol-related offenses in 12-17 year olds between 2007 and 2011.
2. Past 30 Day alcohol use decreased from 2006 to 2009.
3. DUI arrest rates (in terms of total number of arrests) for 16-21 year olds slightly decreased between 2007 and 2011, from 6.63 to 6.41 following a slight increase to 8.03 in 2009.
4. Alcohol-related traffic deaths for all ages showed an initial precipitous decrease between 2007 and 2008.
5. Liquor law and drunkenness arrest rates showed a small decline between 2007 and 2011.

DDAP continues to work on the statewide Multi Agency Safety Team (MAST), to implement the Comprehensive Strategic Highway Safety Improvement Plan, which will include a focus on highway safety issues, including underage drinking and driving. DDAP will be reporting on the following data elements for MAST: persons receiving prevention education on alcohol programs and the percentage of persons who report they have driven under the influence.

In addition to the MAST, DDAP staff was invited this year to participate in the MAST Safety Advisory Committee (SAC). One of the top ten safety focus areas of the SAC is impaired driving.

DDAP collaborates with the DUI Association through The Pennsylvania Department of Transportation to address underage drinking and underage drinking and driving-related issues. DDAP staff serves on the planning committee to assist in their annual conference.

National Guard services have been provided statewide as a result of a Memorandum of Understanding between the Department of Health and the Pennsylvania National Guard Drug Demand Reduction Division. Some of the programs that the National Guard has provided this year include: Project Lead and Seed, Girls on Track and After School Activities.

DDAP has added a new element to PBPS to track prevention services that specifically address the topic of driving under the influence to get a better understanding of the volume and type of services that are being implemented to address this issue.

NEW PLAN PRIORITY: Increase statewide awareness and prevent the misuse/abuse of prescription drugs and related drug overdoses.

Background: Prescription drug misuse/abuse is a growing concern across the nation. Based on state, local and national research and data, DDAP began monitoring and addressing the priority.

According to research conducted by The Partnership at Drugfree.org, as many as one in five teens say they have taken a prescription drug without having a prescription for it themselves. According to National Outcome Measure Surveys (NOMs) that were administered in 2011 in Pennsylvania, 14% of youth surveyed took prescription drugs that were not prescribed to them. In 2011, 18% of youth surveyed felt that prescription drugs were not harmful.

PROGRESS REPORT FY 2012-13

DDAP is working to identify services provided by the Single County Authorities that specifically address the misuse/abuse of prescription drugs. There are several programs that have been used by the SCAs to address this priority, including R.E.A.L, Too Good For Drugs (TGFD), and Leadership/Mentoring Activities.

DDAP is monitoring national trends to ensure the Commonwealth is provided with up-to-date data, research and information.

DDAP is working in partnership with the PA Commission on Crime Delinquency and the Pennsylvania District Attorney's Association to increase the availability of permanent prescription repositories in the Commonwealth. The intent is to reduce the amount of prescription drugs available for potential misuse/abuse.

DDAP staff work collaboratively with the Statewide Injury Prevention and Control Plan Injury Community Planning Group (ICPG) – Falls Prevention in Older Adults Committee to develop a comprehensive and coordinated plan. The plan focuses on preventing injuries and violence across the lifespan by empowering state and local partners, through the collections and analysis of data and the leveraging of resources for injury prevention programs, to recapture lost human potential. One of the topics relates to unintentional poisonings of older adults, which includes prescription drugs.

PAST AND CONTINUING PRIORITY: Improve prevention outcomes through data-driven management.

Background: As DDAP has increased its capacity to collect and analyze data through PBPS and other sources, the importance of and ability to utilize data-driven management has grown. DDAP has utilized and promoted several strategies for collecting and analyzing data that can be used to guide prevention efforts and improve prevention outcomes. Data driven management has primarily focused on the collection and utilization of needs assessment data, prevention service data and evaluation/outcome data.

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Although SAMHSA/CSAP does not require States to collect the National Outcomes Measures (NOMs) survey as part of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), BDAP felt it was important for those receiving services funded by the SAPTBG to respond to the survey questions. BDAP requires SCAs and prevention providers to administer the Adult and Youth (ages 12-18) NOMs once to a sample of single services and recurring service participants from October 1 through November 30 of each year. After administering the NOMs, SCAs are required to record the survey results into the Performance Based Prevention System (PBPS). During FY 2011-12, 12,635 youth 12-18 years of age took the NOMs survey during their participation in BDAP-funded prevention services. During the same time period, 4,989 adults 18 and older completed the NOMs survey while participating in BDAP-funded prevention services.

NOMs survey data from the past five fiscal years reveals that the percentage of both youth and adult respondents reporting that they have driven under the influence of alcohol in the past year has decreased. For the youth NOMs, past 5-year trends show an increase in the percentage reporting no past 30-day use of various substances (e.g., cigarettes, alcohol, marijuana other illegal drugs) and a slight increase in the percentage reporting great or moderate risk of harm from using various substances. The adult NOMs surveys have produced more fluctuating results over the past five years, but there has been a steady

increase in the percentage reporting that they talked to their children about the dangers associated with the use of tobacco, alcohol or other drugs. Below are a selection of findings from the FY 2011/2012 youth and adult NOMs surveys.

FY 2011/2012 Youth NOMs Survey Findings

- 84.3% of youth reported no alcohol use in the past 30 days, a decrease of 2.9%, compared to SFY 2010-2011.
- 65.3% of youth report they have never used alcohol, a decrease of 5.2%, compared to SFY 2010-2011.
- 2.5% of youth reported that during the past 12 months they drove a vehicle while under the influence, a decrease of 1.4%, compared to SFY 2010-2011.
- 41.5% of youth who are working reported they would be more likely to work for an employer who randomly drug and alcohol tests his employees, a decrease of 4.4%, compared to SFY 2010-2011.
- 86% of youth reported they have never used marijuana, an increase of 0.6%, compared to SFY 2010-2011.
- 94.6% of youth reported they have never used other illegal drugs, an increase of 1.5%, compared to SFY 2010-2011.
- 11.1% of youth reported they first used alcohol between the ages of 12-14, an increase of 1.9%, compared to SFY 2010-2011.
- 44.8% of youth reported that people are at great risk of harming themselves physically and in other ways when they have five or more alcoholic beverages once or twice a week, an increase of 1.6%, compared to SFY 2010-2011.
- 59.3% of youth strongly disapprove of someone their age trying marijuana or hashish once or twice, a decrease of 4.9%, compared to SFY 2010-2011.

SFY 2011/2012 Adult NOMs Survey Findings

- 31.4% of the adults reported they took their first drink between the ages 15 and 17, a decrease of 2%, compared to SFY 2010-2011.
- 47% of the adults reported they have never used marijuana, an increase of 5.7%, compared to SFY 2010-2011.
- 43.2% of adults reported they would be more likely to work for an employer who conducted random drug and alcohol tests on their employees, an increase of 2.3%, compared to SFY 2010-2011.
- 11.6% of adults reported that, during the past 12 months, they drove a vehicle while under the influence, a decrease of 7.2%, compared to SFY 2010-2011.
- 32% of adults with children of an appropriate age reported that, during the past 12 months, they have spoken to their children many times about the dangers or problems associated with the use of tobacco, alcohol or other drugs an increase of 2.4%, compared to SFY 2010-2011.

- 42.9% of adults reported that people are at great risk of harming themselves physically and in other ways when they smoke marijuana once or twice a week, an increase of 1.2%, compared to SFY 2010-2011.

SCAs completed a combined treatment/prevention needs assessment to serve as a basis for SCA planning efforts. The Needs Assessment guided SCAs in the collection and analysis of data regarding: 1) use of alcohol, tobacco and other drugs, 2) prevalence of substance use disorder, 3) risk and protective factors that affect substance use, 4) trends impacting prevention, intervention, treatment and recovery efforts, 5) emerging substance use problems, 6) demand for prevention, intervention, treatment and recovery services, 7) resources available and needed for prevention, intervention, treatment and recovery, and 8) barriers to addressing needs that have been identified. Completed needs assessments were reviewed by BDAP and issues/needs common to multiple SCAs were identified.

Data-driven planning of drug and alcohol prevention services was completed by SCAs. Those funding or delivering drug and alcohol prevention services were required to have anticipated measurable outcomes when providing recurring prevention activities. To measure outcomes, recurring services were required to include pre/post tests and/or surveys.

SPF SIG required the use of NOMs as a pre/post test for all recurring services. SCAs who were awarded SPF SIG funding were required to enter NOMs-related data into PBPS, including pre/post tests and six-month follow-up. By reviewing data from various programs, SCAs were able to conduct both process and outcome evaluation and make appropriate revisions to their programming as needed.

To improve the collection of data on prevention programs and services that were implemented, BDAP continued to enhance the PBPS data system by, for example, developing additional reports and adding a report builder within the system. The enhancements allowed for improved data-driven management. BDAP worked with the established Prevention Data Workgroup to make improvements to the PBPS data system, and to decide on additional reports to develop data elements for collection.

BDAP was awarded a one year Strategic Prevention Framework State Prevention Enhancement (SPE) Grant. This grant provided funding to allow for additional enhancements to be made to PBPS. The goal of these enhancements was to develop Pennsylvania's substance abuse prevention infrastructure by improving data collection, data analysis, and training of the prevention workforce. These improvements increased the ability to efficiently and effectively assess needs and plan, and to implement and evaluate prevention services across Pennsylvania.

Specific enhancements to PBPS that were planned for the SPE grant include: adding a Real-Time Data Visualization (RTDV) Dashboard to allow existing data elements in PBPS and other external data to be overlaid and presented in map, chart or table form; creation of a mobile web-based application for PBPS; addition of an evaluation plan module for creating and monitoring evaluation plans; creation of county epidemiological profiles based on data in PBPS; addition of a module that can track services provided to a specific individual; and development of a variety of video-based online trainings for the prevention workforce. Data

to be incorporated into the RTDV as overlay data sets was collected from the following partner agencies:

- Department of Health
  - All poisoning deaths
  - Accidental poisoning deaths
- Department of Transportation
  - Drug and Alcohol related crash data
- Administrative Office of Pennsylvania Courts
  - Drug and Alcohol related offenses by zip code and magisterial district
- Department of Education
  - Dropout data by county, Local Education Area (LEA), and school building
  - Data by school building on infractions, suspensions, expulsions, and truancy

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DDAP required SCAs and prevention providers to administer the Adult and Youth (ages 12-18) NOMs once to all single services that count attendees and recurring service participants from October 1 through November 30, 2012. DDAP is doing a more detailed analysis on the NOMs data that was collected in SFY 2011/2012. This analysis includes looking more closely at differences between different demographic groups, and differences between survey respondents who report that they have heard, read, or watched a prevention advertisement and those who reported they had not. The key findings of this analysis were:

- Perception of risk of use and disapproval of use is significantly higher for those who reported exposure to an ad.

- Among 15-17 year olds, the percentage reporting no past 30 day use for cigarettes, alcohol, marijuana and other illegal drugs was higher for those who reported exposure to an ad.

An overall comparison of those who were or were not exposed to a prevention advertisement shows that reported past use is similar between the two groups but that perception of risk of use and disapproval of use is significantly higher for those who reported exposure to an advertisement. When the exposed and unexposed groups are broken down by age group, differences in reported past use appear for the 15-17 year old age group. Among 15-17 year olds, the percentage reporting no past 30 day use for all substances and no lifetime use for all substances except alcohol and prescription drugs was higher for those who reported exposure to an advertisement. Overall this analysis revealed that there does appear to be some relationship between reported exposure to a prevention advertisement and more

desirable NOMs results. Further investigation will be needed to better understand this potential association.

DDAP encouraged SCAs to administer pre/post tests or surveys for evidence-based and state approved programs as a method of collecting outcomes for these programs/activities.

PBPS is currently being used by DDAP and SCAs to ensure that:

- The six federal strategies are utilized.
- The 25% of program services are delivered through a combination of evidence-based and innovative programs.
- The 20% of services are provided through recurring events.
- Adult and Youth Prevention NOMs are collected at single and recurring services.
- Prevention service data is entered into the Performance Based-Prevention System.

DDAP is analyzing the data collected in PBPS to examine questions such as:

- What program and services are being implemented, and where and to what extent are these programs/services being implemented?
- Who and how many people are being served by various types of programs?
- How are programs and services implemented to address a specific need/issue in a targeted community potentially impacting that need/issue?

This analysis can provide information to better determine potentially underserved populations, and where gaps in service may exist. It can also be used to better coordinate and plan services.

DDAP was awarded a one year no-cost extension for the State Prevention Enhancement (SPE) Grant. During this current fiscal year, DDAP will be working with KIT Solutions to create the enhancements to PBPS that were proposed and defined in SFY 2011/2012. A primary enhancement to PBPS that is being completed is the addition of the Real-Time Data Visualization (RTDV) Dashboard. The mapping and data visualization capacity of this dashboard will allow DDAP, SCAs, prevention providers, and other partners to do more in depth monitoring and analysis of prevention service data entered in PBPS, as well as other data sets such as arrest data, census data, and overdose death data that can be used for needs assessment and evaluation. RTDV will be an important tool in improving capacity for data driven management.

DDAP is working and meeting with SCA and prevention provider staff to plan for future needs assessments that will identify state and local priorities. Discussion is taking place about ways to provide each SCA with more statewide data to combine with local RTDV is being discussed as an important tool for updating and sharing data sets that can be used for future needs assessments.

Current service data entered in PBPS and needs assessment data is being reviewed in order to identify potential service gaps. Greater breadth and quality of prevention services targeting adults, especially the high risk 18-25 age group, is one such service gap. Many of the current prevention services being delivered to adults are focused on parenting and family management topics. Additional prevention services for adults outside of parenting/family management topics are needed. Another identified service gap is the provision of services that fall under the Environmental Federal Strategy. Services focused on environmental level change have the ability to reach/impact a large segment of the population and are key in producing changes in policies, communities, etc., that support and reinforce the individual level behavior change strategies that are implemented. In SFY 2010/2011 and SFY 2011/2012 only approximately 2% of all prevention services entered into PBPS fell under the environmental federal strategy.

As the SPF SIG grant came to an end in September of 2012, SCAs completed final evaluations. Information from these final evaluations, along with other data collected on the SPF SIG grant, was then compiled to create a statewide final evaluation report. The SPF process of identifying priority communities where the magnitude of the problem is greatest and the capacity to address the need is present has been incorporated into all prevention programming in the state. SCAs are required to target programs and services to specific communities that have been identified through data. Communities can be a town, township, borough, a certain number of blocks within a city, or even a specific demographic group.

PAST PRIORITY: Enhance the Pennsylvania prevention system capacity.

Background: DDAP works collaboratively with agencies throughout the Commonwealth to enhance prevention efforts. One component of this effort is to enhance capacity through knowledge. The prevention workforce is required to participate in yearly training. This is to ensure that individuals receive the best prevention services possible to develop/maintain the skills necessary to avoid substance abuse. A key aspect of capacity building is convening key stakeholders, coalitions and service providers to plan and implement sustainable prevention efforts. The mobilization of resources included financial and organizational resources, as well as the creation of partnerships. Readiness, cultural competence and leadership capacity are addressed and strengthened through education and systems thinking.

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BDAP maintained support of current cross-agency efforts by attending committee meetings in conjunction with other departments and agencies throughout the Commonwealth. To ensure adequate representation from BDAP, staff was assigned to each committee. Through collaboration and coordination, partnerships were developed to avoid duplication of substance abuse prevention efforts. All state resources were compiled to be available on an as needed basis to build capacity throughout Pennsylvania.

The Division partnered with the training section at BDAP to incorporate information regarding training into a combined Prevention and Treatment Needs Assessment.

Information about trainings that the SCAs and providers received and the trainings that they needed was collected in the Needs Assessment. This provided an opportunity to note gaps in training specifically related to significant issues/problems/trends that the SCAs identified.

The Division participated in the PA Drug and Alcohol Coalition, whose purpose was to identify and build coordinated systems of care in Pennsylvania capable of collaboratively offering quality health care that addressed the needs and priorities of Pennsylvania regarding substance use and co-occurring prevention, intervention, treatment and recovery. This was funded through the SPE Grant. BDAP, with the assistance of The Institute for Research, Education and Training in Addictions (IRETA), facilitated meetings with the Prevention Committee of the PA Drug and Alcohol Coalition to discuss the development of the Capacity Building/ Infrastructure Enhancement Plan and a five-year Strategic Plan that were required as part of the SPE Grant.

BDAP participated in the Service to Science (STS) national initiative supported by SAMHSA/CSAP to enhance the evaluation capacity of innovative programs and practices that address critical substance abuse prevention or mental health needs within the Commonwealth. STS consists of a combination of training events and customized technical assistance aimed at providing participants with technical assistance that will help programs evaluate their efforts with increasing levels of methodological rigor. In July of 2011, Interrupted - High Risk Youth Intervention Program (a program nominated by BDAP in SFY 10/11), was selected to participate in the STS Program.

BDAP partnered with the Commonwealth Prevention Alliance (CPA). BDAP assisted the CPA in the planning of their annual conference, which provides an important opportunity for the prevention workforce to receive training on a variety of prevention related topics. BDAP also supported the conference by providing BDAP approved trainers.

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DDAP is continuing to support current cross-agency efforts by attending committee meetings that occur in several departments and agencies throughout the Commonwealth. On a monthly basis, DDAP staff continues to update the division on these committees and the partner agencies.

The Division partners with the training section to ensure that prevention related trainings are delivered to the field based on need. Trainings address readiness, cultural competence, and leadership capacity.

As part of the SPE grant, DDAP is working to develop online trainings to address the needs of the prevention workforce.

DDAP is continuing to support the Dauphin County Department of Drug and Alcohol Services' progress in the Service to Science (STS) initiative for their program, "Interrupted – High Risk Youth Intervention Program". Dauphin County Department of Drug and Alcohol Services was recently awarded a Building Evaluation Capacity for Evidence-based

Interventions grant. The purpose of the grant is to support the implementation of evaluation capacity-building efforts for the "Interrupted" program.

DDAP is partnering with the Commonwealth Prevention Alliance (CPA) and is participating in monthly meetings and annual conferences. DDAP is also assisting the CPA in the planning of their annual conference, which provides an important opportunity for the prevention workforce to receive training on a variety of prevention related topics. DDAP also supports the conference through trainers and conference registration.

DDAP staff is working with various committees to support the progress made over the past year including;

- Drug Free Pennsylvania
  - Became more self-sustaining by taking the lead on programs/projects.
  - Increased attendance of media literacy training workshops.
  - Finalized their high school media literacy curriculum.
  - Developed the idea of posting their PSA contest on-line.

- Pennsylvania School Wide Positive Behavioral Support State Leadership Team
  - In 2011, four new sites were added to increase the overall sites to 350.
- Student Assistance Program Commonwealth Interagency Committee
  - Implemented a new K-12 training design.
- Youth and Family Training Institute Advisory Board
  - Trained 25 new family and youth support partners.
  - Collaborating with five new counties and seven new learning counties to provide technical assistance for the upcoming year.
- Statewide Injury Prevention and Control Plan Injury Community Planning Group
  - Working to develop a way to collect emergency room data.
- HIV Prevention Community Planning Group
  - Adopted the new state plan to address the upcoming changes in the Affordable Care Act.

PAST AND CONTINUING PRIORITY: Identify and implement realistic recommendations to positively impact workforce issues within the Commonwealth.

Background: The Workforce Development Committee of the Pennsylvania Drug and Alcohol Coalition worked with the Pennsylvania Certification Board (PCB) to encourage the expanded use of Certified Recovery Specialists (CRS) to help individuals gain access to needed resources in the community by assisting them in overcoming barriers and helping them bridge gaps between their needs and available resources. Working with Committee members, PCB developed a competency based credential for non-degreed counselors.

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The Workforce Development Committee of the Pennsylvania Drug and Alcohol Coalition met and addressed the issues of the field.

One of the specific goals of the SPE Grant was to improve the knowledge and capacity of the prevention workforce. The grant allowed for enhancements to PBPS to include online video-based training of the prevention workforce. DDAP created the scripts for these videos.

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DDAP continued working to create video-based trainings as part of the SPE grant. DDAP has been closely involved with the Commonwealth Prevention Alliance 23rd Annual Prevention Conference to assist in the training and development of professionals in the prevention field.

PAST AND CONINUING PRIORITY: Increase statewide awareness and prevent the use of marijuana.

Background: In SFY 2010/2011 marijuana was the primary drug of choice for 67.1% of SCA paid treatment admissions reported into BDAP's Client Information System (CIS) for individuals under age 18. For SCA paid treatment admissions reported into CIS for those over age 18, marijuana was the primary drug of choice for 12.5%. For SFY 2011/2012, 13.3% of respondents on the Youth NOMs survey reported ever using marijuana. Among just those respondents who were age 15-17, 34.6% reported ever using marijuana. In addition, for the past 5 years approximately 22% of youth respondents reported no or slight risk from smoking marijuana once or twice a week. The Adult NOMs survey results from the past five years shows that roughly half of adults each year report ever using marijuana. Of the five questions on the Adult NOMs survey regarding the potential harm posed by use of certain substances (i.e. cigarettes, marijuana, alcohol, prescription drugs and synthetic drugs), the question on marijuana use had the highest percentage of respondents reporting no or only slight risk of harm from use (28% in SFY 2011/2012).

Pennsylvania has continued to oppose legislation and medical marijuana efforts. Based on local, state and national data and initiatives, increasing the statewide awareness and preventing the use of marijuana was chosen as a priority. Given the legality of medical marijuana in several states and the recent legalization of recreational marijuana use in other states, DDAP will be cognizant of changing attitudes toward the perceived risk/harm of marijuana. DDAP will use data, research and programs to address and prevent the use of marijuana and combat the perception that it is harmless.

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DDAP is working to identify services provided by the Single County Authorities that specifically address marijuana use. The goal is to increase prevention services provided that address marijuana use. There are several programs that have been used by the SCAs to address this priority, these programs include, Too Good for Drugs (TGFD), Project ALERT and Leadership/Mentoring Activities.

DDAP is monitoring national trends to ensure the Commonwealth is provided with up-to-date data, research and program information.

NEW PLAN PRIORITY: Enhance the development of a model curriculum that utilizes pertinent data and information that improves substance abuse prevention.

Background: In Pennsylvania, the model program for prevention follows the Strategic Prevention Framework (SPF) that ensures SCAs adhere to the five steps of the SPF model: Needs Assessment, Capacity, Planning, Implementation, and Evaluation. Cultural competency and sustainability are also incorporated in these five steps.

In 2000, transition toward the use of prevention programs that showed evidence of effectiveness resulting in a change in individuals' substance use and abuse took place. These evidence-based programs were reviewed by CSAP and listed as model programs that showed individual change. As the number of these evidence-based programs began to grow, SCAs and prevention providers were encouraged to utilize those programs that addressed areas of need in their local communities. To help ensure further use of programs that show evidence of effectiveness, DDAP requires SCAs to deliver at least 25% of services through a combination of Evidence-Based and State Approved Programs.

DDAP developed a process in 2012 to examine programs submitted by the SCAs to determine appropriate utilization at the county level. The program review process serves as a formalized method to review prevention programs in order to determine whether they should be added to DDAP's list of evidence-based programs and/or state approved programs, as well as to determine if certain DDAP funding sources can/should be used to fund the programs. The approval process is based on review of the program and whether it utilizes evidence-based practices that have been found to reduce drug and alcohol use, as well as other related risk factors.

DDAP will continue to support increased use of evidence-based programs.

INTERVENTION

The Department of Drug and Alcohol Programs, Bureau of Treatment, Prevention and Intervention, Division of Prevention and Intervention (Division) is responsible to provide for the development, oversight and management of substance abuse prevention and intervention services throughout Pennsylvania. Through programs such as Prime for Life and the Brief Alcohol Screening and Intervention for College Students, DDAP addresses individuals that have used substances and provides them the necessary skills to avoid further use. The major focus is to identify and address individuals currently struggling with substance use and to provide them with the skills to develop healthy lifestyles.

In addition, DDAP requires grantees called Single County Authorities (SCAs) to implement Student Assistance Programs (SAP) that utilize a systematic team approach comprised of professionals from various disciplines within the school districts that may include but not be limited to guidance counselors, teachers, principals, and SAP liaisons from community agencies. The team identifies barriers to learning, and, in collaboration with families, identifies students in need of assistance to enhance their school success. Further, as representatives of the county drug and alcohol service system, professionally trained SAP liaisons provide consultation to teams and families regarding the need for referral to community-based and school-based assessment and intervention for drug and alcohol related problems.

The federal strategy Problem Identification and Referral targets those persons who have experienced first use of illicit/age-inappropriate use of tobacco and those individuals who have indulged in the first use of illicit drugs and alcohol. This helps to assess the ability to change the thinking/behaviors of the individual.

Current Initiatives

- Prime For Life
- Brief Alcohol Screening and Intervention for College Students (BASICS)
- Youth and Family Training Institute Board
- Balanced and Restorative Justice in Pennsylvania
- Pennsylvania School Wide Positive Behavior Leadership Team

NEW PLAN PRIORITY: Enhance strategies and programs that provide individuals with the necessary skills to refrain from future substance use.

Background: In July 2012, the Bureau of Drug and Alcohol Programs became the Department of Drug and Alcohol Programs and the Division of Prevention and Intervention was created. The Division is working to enhance knowledge regarding intervention as well as starting to provide technical assistance. Intervention strategies attempt to address those

individuals that have experimented with alcohol, tobacco and other drugs (ATOD) to modify their behaviors and thoughts.

DDAP, in partnership with the University of Pittsburgh, has developed and submitted a federal grant application to implement Screening, Brief Intervention and Referral to Treatment (SBIRT) in emergency departments and primary care settings in Philadelphia and Allegheny counties.

DDAP is consistently researching up-to-date information through webinars, articles and studies to ensure the Single County Authorities (SCAs) are apprised of pertinent information.

DDAP supports the SCAs in the assessment if individuals at-risk for ATOD use. The risk screening assessments may lead to referral for further evaluation and/or assessment.

DDAP supports departments throughout the Commonwealth that focus on intervention strategies and addressing individuals at risk of substance abuse. Some examples are as follows:

- The Youth and Family Training Institute Advisory Board strives to achieve quality family and youth driven outcomes by advancing the philosophy, practices and principles of High Fidelity Wraparound through training, coaching, credentialing and ensuring fidelity.
- The Disproportionate Minority Contact Committee provides technical assistance and information to ensure that communities are providing substance abuse to at risk minorities.
- The Balanced and Restorative Justice in Pennsylvania Committee works to support the mission of the juvenile justice system.
- The Pennsylvania School Wide Positive Behavior Support State Leadership Team creates and sustains a comprehensive school based behavioral health support system in order to promote the academic, social and emotional well-being of all Pennsylvania's students

PAST AND CONTINUING PRIORITY: Develop and implement a statewide plan to increase awareness regarding Fetal Alcohol Syndrome (FASD).

FASD is a set of mental, physical and neurobehavioral birth defects that are the direct result of alcohol use during pregnancy. FASD is estimated to occur in 1 in 100 live births in the United States annually. Although FASD is 100% preventable, more than 50% of women of childbearing age drink alcohol and 1 in 8 pregnant women drink alcohol. Each year, taxpayers spend an estimated $6 billion nationally to treat children and adults diagnosed with FASD. Substance abusing pregnant women and women with children are an identified priority population for those receiving services through the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. According to the Institute of Medicine, "Of all the substances of abuse (including cocaine, heroin, and marijuana), alcohol produces by far the most serious neurobehavioral effects in the fetus." For all of these reasons, FASD has

been identified as a state priority through the development and implementation of the state FASD Action Plan.

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The statewide FASD Action Plan, which was officially unveiled on September 8, 2008, has been implemented with various action steps being achieved toward meeting the goals of increasing awareness and education about FASD and promoting systems change for those impacted by one of these disorders. DDAP continued to work with the Executive Committee of the State FASD Task Force to provide additional leadership and oversight for mobilization of the Action Plan.

In 2011-2012, the Department conducted various initiatives regarding FASD Awareness. These events have historically been conducted during the week in which FASD Awareness is observed nationally; however, this year, the bureau advocated that observance be extended from a week to a month. This allowed many of the bureau's community partners to expand their efforts, especially in regards to activities delivered within school districts.

Those activities supported directly by the bureau included The Baby Bottle Distribution Project which was conducted for the fifth consecutive year, with 53 obstetric gynecology offices and pregnancy centers distributing 5,472 baby bottles with prevention message inserts to expectant mothers in 41 counties across the Commonwealth. These figures represent an increase in project activity from 2010, as follows:

- A 32% increase in the number of bottles distributed;
- A 17% increase in the number of obstetric gynecology offices and pregnancy centers participating;
- And, a 24% increase in the number of counties represented in the project catchment area.

The Department also distributed over 90,000 pieces of materials obtained through its agreement with the NineZero Project in an effort to relay a unified awareness message across the state. This information was disseminated primarily through Single County Authorities (SCAs) and their community treatment and prevention provider organizations. Women, Infant and Children's (WIC) Programs and some municipal health offices also participated by providing information to their service recipients.

The Department also worked with partners in the Philadelphia area where the FASD Awareness Month Kickoff Event was held on September 9, 2011 in the Mayor's Reception Room, City Hall. While office closures resulting from area flooding prohibited bureau staff from being in attendance, the event was held as scheduled with notable speakers such as Deputy Mayor for Health and Opportunity, Health Commissioner Donald F. Schwarz, MD, MPH, MBA; Commissioner of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services Arthur Evans, Jr., PhD; Representatives from the

Philadelphia FASD Initiative: St. Christopher's Hospital for Children Renee Turchi, MD, MPH, FAAP, and COMHAR's Linda Bamberger, MSW; and keynote speaker and birth mother, Mary DeJoseph, DO, and her son Stephen DeJoseph. About 40 individuals were present at this event.

Overall, awareness initiatives and activities occurred in 63 of Pennsylvania's 67 counties.

The Department also conducted various FASD training opportunities throughout the year.

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By a proclamation issued by Governor Tom Corbett, September is observed as FASD Awareness Month. This coincides with national observances also held during the month. Various activities were supported directly by the Department. This included the annual Kickoff Event, which was held on September 5, 2012, at the Woods Services Foundation, Inc. in Langhorne, PA, and it featured the reading of the Governor's FASD Awareness Month Proclamation, remarks made by Gary Tennis, Secretary of the Department of Drug and Alcohol Programs, and a keynote presentation by Ms. Kathleen Mitchell of the National Organization on Fetal Alcohol Syndrome (NOFAS) in Washington, DC. Various area service providers had display tables featuring their agencies and services. Fifty one individuals were present for this event. The Baby Bottle Distribution Campaign was conducted for the sixth consecutive year, with 56 OB-GYN / Pregnancy Centers distributing 5319 baby bottles with prevention message inserts to expectant mothers in 41 counties across the Commonwealth. In addition, the Department provided materials obtained through its agreement with the NineZero Project in an effort to relay a unified awareness message across the state. Information was sent to Single County Authorities, Health Offices, and Prevention Providers.

In addition, 38 SCAs (as per data entered into PBPS as of October 10, 2012) conducted FASD Awareness Initiatives during the month which included activities such as:

- FASD Trainings
- Distribution of FASD table tents and /or napkins to restaurants and alcohol serving establishments
- Dissemination of information to healthcare providers
- T-shirt campaigns
- Collaborations with local Women, Infant and Children (WIC) Offices
- Collaborations with Nurse Family Partnerships
- Media Campaigns (newspaper, public service announcements, radio talk show)
- Health Fairs
- School Presentations (middle, high school and colleges)
- County FASD Awareness Proclamations
- FASD Walk
- Ringing of the Bells

According to the PBPS data, 73,793 individuals were involved in these county initiatives. With the combined department and various SCA and other partner involvement,

awareness activities occurred in 63 of the 67 counties, with the combined number of over 79,163 Pennsylvanians being reached with the message that there is no safe time or amount of alcohol to consume during pregnancy.

OTHER AREAS OF IMPORTANCE

Problem Gambling

The Department of Health is designated as the lead agency under Act 1 of 2010 for the management of the Compulsive and Problem Gambling Program. The Department is tasked with providing programs for public education, awareness and training surrounding compulsive and problem gambling.

With the increased availability of legalized gambling in Pennsylvania comes increased concern about individual and social costs of problem gambling. The Department will address this concern by increasing problem gambling prevention, education and outreach efforts.

In 2010, a problem gambling prevention needs assessment was conducted by all 47 Single County Authorities (SCA) to profile population needs, resources and readiness to address needs and gaps. The process involved the collection and analysis of data to define problems within each SCA's geographic area. Each subsequent fiscal year, SCAs have the opportunity to apply for a problem gambling funding initiative. Funds are awarded to the SCAs to develop and implement a comprehensive system of problem gambling prevention strategies, and programs. These problem gambling prevention services are provided either directly by the SCAs or their contracted provider(s). Problem gambling prevention program activities are delivered in a variety of settings and, when appropriate, to communities affected by risk factors associated with problem gambling.

The SCAs utilize the Performance Based Prevention System (PBPS) to plan, monitor, evaluate and analyze problem gambling prevention services in order efforts to effective prevention programming. Additionally, PBPS will assist with directing prevention-related policy and funding (refer to the Annual Gambling Report for more detail).

TREATMENT DIVISION INTRODUCTION

The Treatment Division is responsible for program planning and development of standards, policies, guidelines, service descriptions, and outcome data for the clinical functions of case management and treatment systems for drug, alcohol and problem gambling. In addition, the Division is responsible for the program planning, development, implementation and oversight of standards, policies, guidelines, service descriptions and outcome data for compulsive and problem gambling services. A separate report for the compulsive and problem gambling program is developed annually and can be found at: http://www.ddap.pa.gov/gamblingaddiction.

The Division responds to the needs of treatment professionals and publicly funded clients by facilitating program development; evaluating data and research surrounding the development, promotion and implementation of treatment services; assessing training needs for treatment professionals; collaborating with state, county, and provider agencies, to develop programming and coordinate systems which serve the multiple needs of substance abusers throughout the Commonwealth.

NEW PLAN PRIORITY: To develop community-based drug or alcohol abuse treatment services in a cooperative manner among State and local governmental agencies and departments and public and private agencies, institutions and organizations.

This new, overarching priority was established in order to ensure DDAP fulfill the requirements of Act 50. DDAP recognizes that as a state agency it is imperative to have a close working relationship with the SCAs. The SCAs have the knowledge and resources to attack substance abuse at the local level and provide valuable information to DDAP on policy, procedures, and regulations. DDAP collaborates with various county and provider organizations including but not limited to the Pennsylvania Community Providers Association (PCPA), Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA), Pennsylvania Recovery Organization Alliance (PRO-A), Parent Panel Advisory Council (PPAC), Drug and Alcohol Advisory Council (DAAC), and the Drug and Alcohol Services Providers Organization of Pennsylvania (DASPOP). With input from these organizations, effective evidence based programs can be developed and implemented that will help individuals begin and sustain recovery maximizing our limited resources.

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Community based services exist at all levels of care and types of services throughout the Commonwealth. SCAs are required to contract with at least one licensed treatment provider for each level of care and type of service. DDAP has, and will continue to collaborate with stakeholders on the implementation of evidence based programming and the development of new programs. DDAP also monitors contract compliance and licensure standards for these programs, as described below to assist in the maintenance of quality of services.

NEW PLAN PRIORITY: Development of treatment and rehabilitation services for male and female juveniles and adults who are charged with, convicted of or serving a criminal sentence for any criminal offense of this Commonwealth. Provision of similar services shall be made for juveniles adjudged to be delinquent, dependent or neglected.

The cost and community safety benefits of providing treatment for individuals in the criminal justice system have been well documented in the research. DDAP believes that the most effective treatment services are ones that are implemented by trained personnel in an appropriate manner, in the correct duration, and in the right setting. Thus DDAP requires the use of PCPC for adults and ASAM for adolescents as placement criteria. DDAP considers the use of a full continuum of care to be the most effective means to combat drug and alcohol abuse. DDAP partners with PCCD, OCYF, OMHSAS, PBPP, DOC, the Juvenile Court Judges Commission, and others to ensure that the most cost effective, efficient services are

provided to individuals suffering from substance abuse. This allows for individuals to invest more fully in their recovery and become productive members of society.

Treatment services have been developed for juveniles and adults involved in the criminal justice and/or the children and youth system that encompasses the full continuum of care. The PCPC and the ASAM Patient Placement Criteria is utilized for level of care recommendations for adults and juveniles respectively. The PCPC and the ASAM are utilized as placement tools for adults and juveniles involved in the criminal justice and children and youth systems. The PCPC is currently being revised through the Clinical Standards Committee and will encompass updated information on criminality as it relates to substance abuse treatment needs.

NEW PLAN PRIORITY: To offer educational courses for law enforcement officials, including prosecuting attorneys, court personnel, the judiciary, probation and parole officers, correctional officers and other law enforcement personnel, welfare, vocational rehabilitation and other State and local officials who come in contact with drug abuse and dependence problems.

The implementation of the DDAP adds new emphasis to this priority which reflects the need for collaboration and training across a broad range of related agencies. DDAP has developed positive working relationships with various entities (e.g., DOC, PBPP, judges, and OCYF) providing them with technical assistance and a variety of trainings surrounding matters involving drug and alcohol use. These training are designed to expand their knowledge of effectively working with individuals with who abuse drug and/or alcohol. DDAP will continue to explore the development of new courses that will be beneficial to its sister agencies.

DDAP has developed various courses and participates in initiatives for professionals working with substance abusing individuals. Included among these are an "Addictions 101" course for state parole agents and a Screening, Brief Intervention and Referral to Treatment (SBIRT) for Children and Youth caseworkers. DDAP staff have offered training and educational presentations on local and statewide venues for Crisis Intervention Team members, Office of General Counsel, Parole Commissioners, Parole and Probation Officers, as well as reentry staff at the Department of Corrections. Additional trainings are scheduled for addiction professionals, judges and professionals in the legal system.

PAST AND CONTINUING PRIORITY: Establish and maintain a panel of parents to study family and community access to alcohol and drug abuse information, intervention and treatment services and make recommendations.

One in four families in Pennsylvania is affected by untreated alcohol and drug addiction with many of those impacted being adolescents. Untreated substance abuse problems contribute to high dropout rates from school, teen suicide, unwanted teen pregnancy, teen overdoses and crime. Despite the helpfulness of treatment, many teens may not access care because families do not know what services are available or how to access

them. Additionally, our system may not have historically been "user friendly" for adolescents and their families. In order to give families a voice in making information and treatment more accessible, the Parent Panel Advisory Council (PPAC) was established in 2007, in accordance with House Resolution 585 of 2006. Representing parents across the Commonwealth, individuals serving on this council advise and make recommendations to the Department for system improvement in light of the personal experiences they have had with their sons and daughters. The top priority recommendation from PPAC was the establishment of DDAP.

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House Resolution 585 tasked the PPAC to study and address family and community access to drug and alcohol abuse information, intervention and treatment services and to make recommendations to the House of Representatives Health and Human Services Committee and the Bureau. Recommendations included increasing education on the process of accessing care when needed. As a result, PPAC presented at the Pennsylvania Community Providers' Association (PCPA) Conference held at Seven Springs, PA on October 6, 2010 and at the Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA) meeting in State College, PA, on October 20, 2011, as well as various other venues, offering a voice to the needs of the family.

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PPAC continued to meet this fiscal year in efforts to provide continued feedback to the Department. PPAC and the Pennsylvania Drug and Alcohol Advisory Council (DAAC) have established a working partnership in efforts to improve the substance abuse service system. Two meetings have occurred thus far, resulting in preliminary plans to form at least two collaborative workgroups with one group exploring the possibilities and approaches for networking with physicians and emergency departments to improve their awareness of substance use disorders and services available; the other group would establish a plan for conducting statewide regional focus groups to identify family needs as it relates to substance use disorders. Both workgroups address areas of concern and recommendations proposed by PPAC and are of mutual concern for the Drug and Alcohol Advisory Council.

Additionally, many of the PPAC members are involved in local initiatives or are involved in other state affiliated committees which parallel or support their official recommendations made to the House Health and Human Services Committee. This group of individuals remains very active in providing input to the Department.

Through interdepartmental collaboration between DDAP and other state agencies another priority of PPAC is being addressed through disseminating information on how to access treatment services. By providing this information through various meetings, conferences, etc., DDAP has improved the knowledge base of both state and local agency personnel on how to access substance abuse treatment. Additionally, through collaboration with other agencies DDAP is able to explore accessing additional funding sources which may provide for more opportunities for individuals to enter treatment.

PAST AND CONTINUING PRIORITY: Maintain a Recovery-Oriented Systems of Care (ROSC) within the Commonwealth that supports a recovery management model through coordinated networks of community-based services and supports that are person-centered and strength-based.

"A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems." The central focus of a ROSC is to create an infrastructure or "system of care" with the resources to effectively address the full range of substance use problems within communities, in partnership with other disciplines that are individualized, strength-based and person-centered that is available pre-recovery engagement through long term recovery management. ROSC implementation and a focus on recovery is an identified item of importance by the Substance Abuse and Mental Health Services Administration (SAMHSA) as is seen by inclusion of recovery in its identified initiatives, as well as its emphasis of ROSC and recovery in the Substance Abuse Prevention and Treatment (SAPT) Block Grant application, various discretionary grants offered by the agency, and a vast array of SAMHSA sponsored webinars and trainings.

Technical Assistance Opportunities and through the provision of training individuals at the state level regarding implementation practices. This model of care has been substantiated by research indicating that fewer than 10% who need treatment obtain it; once people access treatment retention and continuing care may be limited.. Additionally, it takes 4 to 5 years to reach stability of alcohol recovery and longer for other substances. Most individuals who resume their use of AOD will do so in the first 90 days following treatment. These factors further substantiate the principles and elements of ROSC which encourage continual peer based recovery supports across the lifespan, self-management, warm linkages within the individual's community, etc.

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The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) has been in support of ROSC and has been encouraging states to adopt the recovery management model of care. The Department had been moving in this direction since attending CSAT's National Summit on Recovery in 2005. To further support this transition, Department staff, along with invited state department colleagues, participated in its first of several Technical Assistance Trainings with CSAT on May 17, 2010. The Department also encouraged the local implementation of ROSC by requiring the inclusion of ROSC planning in the Treatment Needs Assessments and Treatment Plans submitted in 2010 by the Single County Authorities and by encouraging Single County Authorities to begin to assess their capacity for ROSC through inclusion of this concept in its 2010 -2015 Grant Agreements.

In conjunction with the Department of Public Welfare's (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS), the Department supported two

committees to facilitate the implementation of ROSC. The Recovery Based Issues Committee of the Pennsylvania Drug and Alcohol Coalition studied nationally published information about a ROSC and made recommendations regarding the transition to ROSC in Pennsylvania from the perspective of the recovery community. The Persons in Recovery Committee, a subcommittee of the OMHSAS Advisory Council, was established to provide OMHSAS and the Bureau with feedback, dialogue, input and recommendations on systemic issues pertaining to drug and alcohol program development and implementation and recovery-oriented systems of care.

In August 2010, Department staff along with Ms. Charlene Givens and Ms. Cheryl Floyd made up a team representing Pennsylvania at the Addiction Technology Transfer Center (ATTC) ROSC Training of Facilitators. This three-day training was sponsored by SAMHSA in an effort to educate additional individuals to assist the "national experts" in providing technical assistance and training at the state level. This team has been utilized, in addition to the technical assistance being obtained directly through CSAT, to further educate stakeholders at the state and county level about ROSC and to provide transition assistance as necessary. These trainings continued into 2011-2012 through direct training efforts of the Department and through a contract with a Recovery Community Organization, which provided four Technical Assistance Opportunities on this subject.

Throughout the course of the year, various trainings and presentations were conducted within the bureau itself in order to assist staff in understanding ROSC and how to differentiate the existing system from what is proposed through the implementation of ROSC. These training and presentations enhanced staff's ability to effectively assist individuals at the county and local levels with the implementation of ROSC. Topical Informational Summaries were submitted to staff on at least a monthly basis, with opportunities to interact regarding the information presented to assure that the information presented was being adequately processed and understood. The Internal ROSC Implementation Team (which also included OMHSAS staff) met regularly to evaluate the current system and strategize ROSC implementation. This culminated in a two-day planning meeting that was held in February 2012, from which a preliminary strategic plan was established. However, because of time constraints necessitated by the transition from the bureau to the department, all action on this particular initiative has been suspended, with the exception of continued participation in training opportunities of key staff.

The Persons in Recovery Committee of the OMHSAS Advisory Council continued to meet and establish ongoing goals for the implementation of ROSC. The Recovery Based Issues Committee of the Drug and Alcohol Coalition remains on hiatus, having met only once in this year.

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The Department continues to have key staff participate in trainings offered by SAMHSA relevant to this topic. Staff also continues to provide leadership to the PIR Subcommittee of OMHSAS's PIR Subcommittee of its Advisory Council. Currently, the Department is assessing how ROSC Implementation will be addressed moving forward.

The Department continues its partnership with the PA Recovery Organization Alliance. Additionally the Department has initiated the establishment of statewide training availability on the effective use of community based recovery resources such as 12 step programs.

In December 2012, various Department staff met with and observed staff from Pennsylvania Recovery Organization – Achieving Community Together (PRO-ACT) and NorthEast Treatment Centers (NET) in Philadelphia to obtain information about their delivery of recovery support services and data collection process within the setting of a Recovery Center. Direct observation of service delivery and data processing provided greater insight regarding implementation options, strategies, and data processing that can be adopted by service providers in other areas of the state. Both site visits included interviews with participants who gave testament to the benefits of recovery supports and how involvement as a peer allowed them personal opportunities in their own recoveries as well as the ability to assist others' with theirs, thus substantiating the benefits of these services and a ROSC. to this particular site visit, other information garnering activities were done by Department staff, including participation in various nationally supported webinars on the topic.

PAST AND CONTINUING PRIORITY: Provide screening, testing, referral and case management services for individuals at risk for Hepatitis C.

Hepatitis C virus (HCV) infection is the most prevalent chronic blood-borne infection in the United States. People who inject drugs are at high risk for becoming infected with HCV from sharing needles and drug use paraphernalia. The majority of people with hepatitis C are asymptomatic. Without diagnosis and treatment, 15% - 40% of those persons living with viral hepatitis will eventually develop liver cirrhosis or hepatocellular carcinoma.

Because of the high burden of chronic HCV infection in the United States and because no vaccine is available for preventing infection, national recommendations emphasize other primary prevention activities, including screening and testing blood donors, inactivating HCV in plasma-derived products, testing persons at risk for HCV infection, providing them with risk-reduction counseling and consistently implementing and practicing infection control in healthcare settings.

Pennsylvania's Hepatitis C Outreach, Education and Screening/Detection Project was initiated in Philadelphia in the latter part of State Fiscal Year 2005-2006 through special provisions from the Center for Substance Abuse Treatment in which the HIV set-aside funds from the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) were used to support outreach, education and screening/detection of Hepatitis C in substance using individuals. The Project is a collaborative effort between the Department of Drug and Alcohol Programs, the Department of Health's Bureaus of Communicable Diseases and Epidemiology and Genentech, a Member of the Roche Group.

In State Fiscal Year 2006-2007 the Hepatitis C Project became entirely State funded and was expanded to include four additional projects: Allegheny, Blair, Clearfield/Jefferson and Northampton, which continued through State Fiscal Year 2007-2008. Blair County

discontinued the program during State Fiscal Year 2008-2009, while the other counties have continued.

In 2005, the first year of the project's operation, the rate of reported cases of hepatitis C in Pennsylvania was 1 per 100,000 population and this rate trended significantly lower in 2006 (.4 per 100,000 population), 2007 (.3), 2008 (.2), 2009 (.3) and the most recent calendar year reported by the Centers for Disease Control, 2010 (.2).

The Pennsylvania Hepatitis C Project is making a difference by relieving the suffering caused by hepatitis C, removing obstacles to patient recovery and reducing healthcare costs downstream through education, testing and referral to treatment.

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In Fiscal Year (FY) 2011-2012, a total of $564,000 was allocated to four SCAs through the drug and alcohol appropriation for the Hepatitis C Project. This included $212,935 to Philadelphia, $122,280 to Allegheny, $106,165 to Clearfield/Jefferson and $122,620 to Northampton counties. Coordinated through Mercy Behavioral Health, Allegheny's Hepatitis C Project consisted of 24 sites, seven of which were methadone providers. Clearfield/Jefferson's project consisted of 12 sites, including one methadone provider. Northampton's project was operated through New Directions Treatment Services and consisted of 8 sites, one of which was a methadone provider. Philadelphia's project consisted of 39 project sites, eleven of which were methadone providers.

Through annual meetings with all the Hepatitis C Project sites, the Department of Health's Bureaus of Communicable Diseases and Epidemiology, Genentech Inc., and the Philadelphia Department of Public Health, the Bureau of Drug and Alcohol Programs continued to ensure that the sites adhered to established protocols in providing Hepatitis C services in the Commonwealth of Pennsylvania. Allegheny, Clearfield/Jefferson, Northampton and Philadelphia SCAs continued screening, testing, counseling and case management services for clients at risk for Hepatitis C. All sites were fully operational and compliant with all reporting requirements.

In FY 2011-12, the Hepatitis C Project encompassed three service areas: Outreach, Testing and Case Management. The following State Fiscal Year 2011-2012 data are inclusive of all four projects with the exception of the Outreach component, which only includes performance measure data from Allegheny, Clearfield/Jefferson and Northampton SCAs. Outreach data indicates that 3,892 persons were contacted in the three SCAs that collected the data. In addition, 1,068 persons were referred for testing. Pre-test counseling was provided to 9,741 clients in the four SCAs. One hundred percent of the persons tested received pre-test counseling. Overall, 4,278 individuals or 44% tested positive. Also, 6,201 persons or 64% received post-test counseling. Case management data indicates that 4,277 individuals were referred for medical evaluation this year. Since the Philadelphia SCA does not currently report treatment and vaccination related case management data, the following is based only on the other three SCAs' data. Two hundred and two persons received Hepatitis A and B vaccines, representing an increase of 23 clients as compared to the prior year.

All four SCAs provided testing and case management services in FY 2011-12. In addition, the Allegheny, Clearfield/Jefferson and Northampton SCAs conducted many outreach activities to promote their projects within their service areas. The Allegheny SCA incorporated information about the IL28B gene and two newly approved protease inhibitors into their educational information; attended educational sessions regarding the use of the new protease inhibitors in conjunction with interferon and ribavirin in the treatment of HCV and began to use the new inhibitors in their "Community C" wellness clinic; opened a Viral Hepatitis Drop-In Center; and was awarded funding from Vertex Pharmaceuticals, Inc. to conduct screenings in recognition of National Testing Day (May 19). Clearfield/Jefferson provided HCV educational materials at local community health fairs, college campuses and social service agencies; facilitated hepatitis education classes in cooperation with the Clearfield County Probation Office and County Jail; promoted the screening project and vaccine clinics via newspaper and radio advertisements; participated in Rural Health Consortia meetings; and produced an educational booklet in cooperation with Dr. Tuesdae Stainbrook. Northampton promoted HCV services among active clients during individual and group sessions and service providers; attended meetings (what kind of meetings?) and participated in community activities; provided case management services and follow-ups (follow-up is a part of case management services) to clients receiving drug treatment services within the Northampton County area; and participated in the Latino Leadership Alliance Health Committee.

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The Department of Drug and Alcohol Programs provide funding to Allegheny, Clearfield/Jefferson, Northampton and Philadelphia SCAs for the provision of screening, testing, counseling and case management services for clients at risk for contracting Hepatitis C. All sites are fully operational and compliant with all reporting requirements. Through annual meetings with all the Hepatitis C Project sites, the Department of Health's Bureaus of Communicable Diseases and Epidemiology, Genentech Inc. and the Philadelphia Department of Public Health, DDAP continues to ensure that sites in the Commonwealth of Pennsylvania adhere to established Hepatitis C service protocols.

DDAP is also collaborating with Department of Health Epidemiologist Sameh Boktor, MD in support of the Federal Centers for Disease Control and Prevention (CDC) Viral Hepatitis – Prevention and Surveillance funding opportunity that Dr. Boktor was awarded in the fall of 2012 (Agency Funding Opportunity Number CDC-RFA-PS13-1303). The purpose of the one-year funding award is to support activities intended to improve the delivery of viral hepatitis prevention in healthcare settings and public health programs and support active, enhanced surveillance to monitor the burden of acute and chronic viral hepatitis.

Dr. Boktor , with DOH, will direct the development and delivery of high risk adult hepatitis prevention webinars and educational booklets intended to educate public health nurses employed by the Department of Health and substance use case managers associated with the Department of Drug and Alcohol Programs through the provision of Pennsylvania's CDC grant. Dr. Boktor will also conduct active, enhanced surveillance for viral hepatitis and collect more extensive and complete surveillance information than is possible through the passive National Notifiable Disease Surveillance System (NNDSS). DDAP will review and

provide input regarding project materials, serve as the liaison between the project and participating substance use case managers and incorporate the results of Dr. Boktor's enhanced surveillance into its executive decision making process.

PAST AND CONTINUING PRIORITY: Maintain the Clinical Standards Committee (CSC) to make recommendations to DDAP regarding the best practices and the identification, assessment, placement and treatment of alcohol and other drug problems for citizens of Pennsylvania.

The Clinical Standards Committee advises DDAP to ensure the use of best practices within the Commonwealth. The CSC's primary task for the past three years was to review the Pennsylvania Client Placement Criteria (PCPC) regarding implementation, utilization, content, and structure; and to identify, review and recommend evidence based practices that may benefit the substance abuse treatment field. The PCPC is the medical necessity criteria utilized by DDAP and the Department of Public Welfare, as designated in Act 152 of 1988.

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The CSC was reconvened in February 2009 and consists of representatives from treatment providers, Single County Authorities (SCAs), Managed Care Organizations, physicians, recovery advocacy organizations, educational institutions and state agencies. The immediate goal of the CSC was to review the Pennsylvania Client Placement Criteria (PCPC) regarding implementation, utilization, content and structure for relevance and merit. Eight subcommittees were formed to assist in the review of the PCPC: the American Society of Addiction Medicine (ASAM) - PCPC Crosswalk; Co-Occurring Disorders; Criminal Justice; Cultural Competency and Sexual Orientation; Screening, Brief Intervention and Referral to Treatment (SBIRT); Pharmacotherapy; Women/Women with Children; and PCPC Utilization. Each subcommittee was tasked with reviewing and revising the special considerations papers that are included in the current PCPC.

The CSC continued to meet less frequently, as the work of the large committee has been completed. The CSC continued its work in revising the PCPC regarding implementation, utilization, content and structure for relevance and merit. The guiding principles were revised based on feedback from CSC members. Two new subcommittees, Re-write and Review, were formed in order to complete the PCPC revision.

The Re-write Subcommittee's work commenced as follows:

- Revise the introduction section of the PCPC
- Finalize the guiding principles
- Revise each section of the placement criteria, incorporating the changes as recommended by the subcommittees

The Review Subcommittee was formed to review the content of the revised PCPC. The Review Subcommittee will begin its assignment when the Re-Write group has completed its charge.

In preparation for completing the revision of the PCPC, the CSC chairs are investigating the possibility of engaging a technical writer in order to ensure cohesiveness of the revised PCPC document.

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The Department has been successful in securing a technical writer, and has contracted with the University of Pittsburgh, Program Evaluation and Research Unit (PERU), to complete a systematic revision of the PCPC based on the work of the CSC. PERU's work will be completed in two phases. Phase one includes revisions to the PCPC document. The most significant revision is the addition of a new level of care, Intervention.

Intervention is defined by the CSC as: *evidence-based actions applied to individuals who are engaging in hazardous alcohol and drug use for the purpose of reducing their alcohol and drug use risk.* Intervention is not substance use disorder treatment. There is recognition in the SUD field that educational and motivational approaches serve as viable methods to address the needs of individuals exhibiting problematic patterns of substance use that do not meet diagnostic criteria for a substance use disorder. Intervention is designed to focus on individuals who are engaging in hazardous substance use and provide them with education to develop the skills necessary to reduce his or her substance use risk. Additionally, Intensive Intervention may be utilized for individuals who are unable or unwilling to access appropriate substance use treatment. In this case, Intensive Intervention can provide individuals with a means to enhance or maintain motivation to access and engage in appropriate substance use services.

A second area included in the revision of the PCPC is the special topic papers. These papers are currently included in Appendix A: Special Needs and Considerations. In the development of the special topic papers, each of the subcommittees strived to make the papers more culturally aware and responsive to the needs of individuals seeking SUD treatment services.

The Pharmacotherapy paper nomenclature has been changed to Medication Assisted Treatment, and includes an expanded discussion of medications typically used in MAT, a list of considerations for determining the appropriateness of MAT for an individual, and an emphasis that MAT is a comprehensive treatment approach.

The Co-Occurring paper eliminates "dual diagnosis" terminology, and includes assessment considerations, co-occurring treatment principles, placement considerations, and lists a number of resources for additional information about treating individuals with co-occurring substance use and mental health disorders.

Women (including those with children) face a variety of issues that have an impact on their ability to attend and participate in SUD treatment, and the paper has been revised to include a new emphasis on barriers to treatment, gender-specific needs, and the importance of trauma-informed care. It is also recommended that changes to PCPC be non-sexist, non-judgmental, and inclusive in language.

The Cultural and Ethnic Considerations and Sexual Orientation papers have been expanded to include an emphasis on the importance of cultural sensitivity in SUD treatment,

whether the considerations are cultural, ethnic, or sexual orientation/identity in nature. Individuals involved in SUD treatment need to feel safe and not feel that they will be judged or face recrimination because of their culture, ethnicity or sexual orientation.

The Criminal Justice paper was not included in the previous version of the PCPC because it was not completed until July 2004. The criminal justice paper was published as a Research to Practice Brief: *Understanding and Treating Substance Use Disorders Among the Criminal Justice Population*. All sections of the original paper have been revised and now includes emphasis on assessment and placement considerations and challenges, systems collaboration, and recovery considerations.

Based on the preliminary timeline developed by PERU, revisions of the PCPC document will be completed by June 2013 with testing and training completed by December 2013. Feedback from the CSC members will be requested and incorporated as part of the revisions to each portion of the PCPC.

NEW PLAN PRIORITY: Collaborate with state agencies in the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of drug and alcohol abuse and dependence problems so as to avoid duplications and inconsistencies in the efforts of the agencies.

DDAP has initiated meetings with state agencies for the purpose of collaboration on issues surrounding substance abuse. These relationships allows for candid conversations with leaders in the state regarding the impact of drug and alcohol abuse on their agencies and clientele. DDAP provides training and education surrounding substance abuse issues to state agencies and their local constituencies. DDAP will provide technical assistance to these agencies on best practices in the field, optimizing resources.

DDAP staff have been meeting with various state agencies (i.e., Pennsylvania Commission on Crime and Delinquency; Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services; Pennsylvania Department of Education; Pennsylvania Department of Health, Bureau of Health Statistics and Research; Pennsylvania Department of Health, Bureau of Health Planning; Pennsylvania Department of Health, Bureau of Communicable Diseases; Pennsylvania Department of Transportation; Pennsylvania Department of Corrections; Pennsylvania State Police; Pennsylvania Board of Probation and Parole, Pennsylvania Department of Aging, Pennsylvania Civil Service Commission, etc.), to discuss the coordination of substance abuse services throughout the Commonwealth. Cross system initiatives have been implemented with the PA Commission on Crime and Delinquency, Department of Public Welfare, Department of Corrections, State Probation and Parole, and the Department of Education.

NEW PLAN PRIORITY: Coordination of efforts relating to vocational rehabilitation, workforce development and training.

Workforce development is a key area to the success of effective prevention, intervention and treatment of substance use disorders. This includes a number of areas of need such as training, job satisfaction, and reduced administrative burdens. These are some of the elements of a comprehensive recruitment, training and retention strategy to support employment in the field.

DDAP staff has been meeting with the Institute for Research, Education and Training in Addictions (IRETA) regarding a variety of health research projects including, but not limited to, the development of problem gambling performance measures for both prevention and treatment and development of clinical consultation services for clinicians certified in problem gambling. Through coordination with IRETA; training on Screening, Brief Intervention and Referral to Treatment (SBIRT) has been presented to case managers, clinicians, and healthcare providers throughout the Commonwealth. DDAP has supported trainings on evidence based practices through the PA Certification Board (PCB) and the PA Recovery Organizations Alliance (PRO-A). Through these trainings, workforce development has been sustained and improved. Additionally, DDAP supports the use of surveys to determine training, development, and resource needs in the field.

DDAP worked with the University of Pittsburgh to assist in revising the Pennsylvania Client Placement Criteria (PCPC). The University of Pittsburgh will also be testing the revised instrument for validity, as well as developing and providing training on the areas of the instrument that have been updated.

Additionally, DDAP has met with various stakeholders regarding the development of a comprehensive strategy to increase entry into our workforce, to ensure appropriate training and support is available, and to reduce unneeded administrative requirements that reduce job satisfaction and retention.

NEW PLAN PRIORITY: Coordinate all health and rehabilitation efforts to deal with the problem of drug and alcohol abuse and dependence, including, those related to senior citizens and social security.

As the "baby boomer" generation ages, DDAP expects more older adults in need of substance abuse services. The number of older adults with substance abuse problems is estimated to increase from 2.5 million in 1999 to 5.0 million in 2020. As people age, they will place increasing demands on the substance abuse treatment system and this will require a shift in focus to address the special needs of an older population of individuals with substance use disorders. There is also a need to develop improved tools for measuring substance use and abuse among older adults. With 367,586 Pennsylvanians receiving Social Security and a substance use problem prevalence rate of 4.5% for individuals aged 50 and over, the number of Pennsylvanians on Social Security with a substance use problem is over 165,000. Additionally, because the older population is more likely to be on prescription medications, it is imperative that they understand the dangers involved when combining an opioid pain reliever with some prescription medications.

DDAP staff is working with various agencies (i.e., Pennsylvania Behavioral Health and Aging Coalition, Department of Aging, Office of Mental Health and Substance Abuse Services, etc.) throughout the state to discuss ways to collaborate and provide services to senior citizens affected by substance abuse. Prescription takeback efforts are particularly important with this population since leftover medications may be inappropriately accessed by others in the household.

NEW PLAN PRIORITY: Coordination of all health and rehabilitation efforts to deal with the problem of drug and alcohol abuse and dependency, including, those related to law enforcement assistance, highway safety, parole and probation systems, jails and prisons, and juvenile delinquency.

DDAP has been meeting with various parts of the criminal justice system for the express purpose of beginning the necessary collaboration on our mutual areas of interest. With 70% of individuals incarcerated having substance abuse issues it is particularly vital that DDAP works closely with agencies that support criminal justice initiatives. There is a significant overlap in clientele between criminal justice agencies and DDAP and by working together best practices can be instituted by all parties that effectively address the offenders drug and alcohol problem, reducing recidivism and increasing community safety.

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DDAP implemented a pilot this year in partnership with the Department of Public Welfare, Single County Authorities, local County Assistance Offices and local criminal justice officials designed to increase offender access to needed addiction treatment services. The pilot includes a drug and alcohol assessment completed at the jail and an application for Medical Assistance (MA) being submitted for those in need of treatment prior to release so that MA can be started at time for release for MA eligible offenders. This pilot will be implemented with state corrections in SFY 2013-2014.

Additionally, DDAP has worked with the Clinical Standards Committee Criminal Justice Subcommittee to clearly define standards for assessment of individuals leaving correctional settings. This subcommittee includes representatives from State Probation and Parole, Department of Corrections, and treatment providers with specialized expertise with criminal justice populations.

The DDAP has collaborated with many components of the criminal justice system including local judiciary, PA Commission on Crime and Delinquency (PCCD), PA Board of Probation and Parole (PBPP), and the Department of Corrections to discuss best practice in developing a comprehensive strategy on the issues of substance abuse as it impacts the adult and juvenile justice systems. Through these newly developed partnerships DDAP expects to avoid duplication in resources and time while implementing best practices. Additionally, DDAP will partner with these and other criminal justice agencies to implement research and education that will inform quality services to individuals involved in the criminal justice system.

DDAP participates on DOC's Re-entry Committee as well as their 2nd Chance Grant oversight committee. This grant provides services to women with co-occurring disorders in the institutions and upon their return to Philadelphia, Allegheny and Dauphin Counties.

NEW PLAN PRIORITY: Encourage collaboration of efforts relating to health professionals, hospital and medical facilities.

The Affordable Care Act, or federal health reform, will most likely have a profound effect on the way people receive health care. DDAP has taken steps to initiate relations with various healthcare professionals who come in contact with substance abusing individuals. In 2010, there were 1,946 overdose deaths in Pennsylvania, which translates into a rate of 15.5 per 100,000. It is imperative that collaborations be made; including working with the Pennsylvania Medical Society to help physicians better understand prescription abuse issues, the development of tamper resistant opioids, and drug take back programs. DDAP is at the forefront of having physicians trained on Screening, Brief Intervention and Referral to Treatment (SBIRT) especially Emergency Room physicians who come in contact with many individuals who have health related problems and are without healthcare coverage. Examples of this can be seen in our collaborations with University of Pittsburgh and IRETA, two key leaders in the field of SBIRT, as well as attempts to gain additional federal grant funding to expand SBIRT. Additionally, through DDAP's Hepatitis C Project and the Methadone Death and Incident Review Team physicians are providing direct input on substance abuse issues that are adversely affecting Commonwealth residents. DDAP continually investigates funding opportunities to ensure additional physician education can take place.

NEW PLAN PRIORITY: Encourage collaboration of efforts relating to mental health professionals and community mental health centers.

In that underage drinking (28% prevalence rate for past month alcohol use in individuals aged 12-20 in PA) and prescription drug abuse (6% prevalence rate of non-medical use of pain relievers in individuals aged 12-17 and drug overdose deaths at 1,946 for the year 2010, which translates into a rate of 15.5 per 100,000 population) are significant issues that directly impact youth, DDAP is making a concentrated effort to address these issues. Through the use of drug take back programs and offering the evidence based Life Skills Training Programs to school districts throughout the state DDAP is using its influence as a department to impact the use of prescription drugs by youth.

Additionally, through the use of the SCA Needs Assessments DDAP is able to determine the issues and concerns at the local level relative to the use of substances by adolescents and thus plan accordingly to address them. With the use of the Student Assistance Program (SAP) in school districts across the state adolescents are able to be identified and services can begin at the earliest possible moment to lessen the impact of substance abuse.

NEW PLAN PRIORITY: Facilitate collaboration of efforts relating to educational assistance, education professions development, higher education, elementary and secondary education for those with substance use disorders.

In that underage drinking (28% prevalence rate for past month alcohol use in individuals aged 12-20 in PA) and prescription drug abuse (6% prevalence rate of non-medical use of pain relievers in individuals aged 12-17 and drug overdose deaths at 1,946 for the year 2010, which translates into a rate of 15.5 per 100,000 population) are significant issues that directly impact youth, DDAP is making a concentrated effort to address these issues. Through the use of drug take back programs and offering the evidence based Life Skills Training Programs to school districts throughout the state DDAP is using its influence as a department to impact the use of prescription drugs by youth.

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NEW PLAN PRIORITY: Support substance-related efforts related to Commonwealth employees benefits and civil service laws.

DDAP is committed to ensuring that quality prevention, intervention, and treatment services are available for all citizens of the Commonwealth. The department is prepared, if needed, to provide input and technical assistance to the various unions and health plans in crafting their substance abuse benefits packages. DDAP is available to the Civil Service Commission to provide feedback on laws that impact individuals with substance abuse issues. By working together all entities can craft a benefit package that will improve the health and work performance of Commonwealth employees.

NEW PLAN PRIORITY: The formation of local agencies and local coordinating counsels, and promotion of cooperation and coordination among such groups, and encouragement of communication of ideas and recommendations from such groups to the Pennsylvania Advisory Council on Drug and Alcohol Abuse

It is the position of DDAP that no central authority can determine precisely what services are necessary in each of the 67 counties of the Commonwealth. Therefore, 47 Single County Authorities (SCAs) have been established so that local input can be provided to DDAP in a logical and coordinated manner. Advisory councils, at the state and local level, have been established so that input can be provided by consumers of drug and alcohol services, family members and treatment providers on policy, procedure, evidence based practices, research, regulation, and training matters.

DDAP regularly meets with the SCAs individually and through their organization, the Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA), to discuss issues of importance related to substance abuse services. Their concerns may be addressed on an individual basis or as appropriate through PACDAA meetings and at Advisory Council meetings. Representatives from PACDAA regularly attend Advisory Council meetings.

NEW PLAN PRIORITY: Development of model drug and alcohol abuse and dependence control plans for local government, utilizing the concepts incorporated in the State Plan.

The development of the state needs assessment and plan will provide a model for local planning. At the local level the use of advisory councils and stakeholder workgroups, to assess local data and enables each SCA to obtain information about prevention and treatment issues that directly impact their community.

NEW PLAN PRIORITY: To cooperate with organized medicine to disseminate medical guidelines for the use of drugs and controlled substances in medical practice.

Medical providers play a key role in prevention, problem identification and referral for treatment. Physician prescribing practices for controlled substances can impact on the prevention or development of drug problems. DDAP will work with the medical community to disseminate best practices related to frequently abused drugs as well as on the implementation of Screening, Brief Intervention and Referral to Treatment.

NEW PLAN PRIORITY: To ensure coordination of research, scientific investigations, experiments, and studies related to the cause, epidemiology, sociological aspects, toxicology, pharmacology, chemistry, effects on health, dangers to public health, prevention, diagnosis and treatment of drug and alcohol dependence and to ensure confidentiality of the individuals who are the subject of scientific investigation or research is maintained.

Given our growing dependence on computers and the need for databases and registries, protection of an individual's privacy is paramount. A breach of confidentiality violates a person's rights and poses a risk of dignitary harm to the research participant, ranging from social embarrassment and shame, to stigmatization. Participation in research is voluntary and DDAP fully recognizes its obligation to protect confidentiality. The Belmont Report (1979), written by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, is the major ethical statement guiding human research in the United States and is the basis for U.S. federal research protections. The report sets out three fundamental ethical principles: respect for persons, beneficence, and justice.

Through cooperative activities with IRETA, DDAP is investigating how best to maximize the potential for research and scientific activities that will impact the substance use field. Working with the University of Pittsburgh, Program Evaluation and Research Unit (PERU), the PCPC is being revised to more fully meet the needs of clinicians in the state. The PCPC has a full continuum of care (outpatient through residential care options) and allows for special needs considerations (Medication Assisted Treatment, co-occurring disorders, criminal justice, etc.) when a clinician is working with a person to make a level of care determination. With PA having the full continuum of care, which encompasses evidence based practices, it is possible for research to begin on how best to utilize funding for all levels of care.

DDAP has begun to explore opportunities for research that may be available.

NEW PLAN PRIORITY: Investigate methods for the more precise detection and determination of alcohol and controlled substance in urine and blood samples, and by other means, and publication on a current basis of uniform methodology for such detections and determinations

DDAP encourages the sharing of information around drug testing developments and technologies through the use of its Listserve and website. As information is gathered this material is passed to the field in an expeditious manner. Trainings on drug testing are reviewed for possible inclusion in an educational curriculum to the field. Specific trainings on synthetic drugs will be offered so that the field is informed on the detection of and the effects of these drugs.

As appropriate, DDAP and staff from the Pennsylvania Department of Health, Bureau of Laboratories review best practices in testing methodology and provides information to the substance abuse field. DDAP staff are monitoring trends in the area of effective drug testing, and support training in these best practices. Current trends include the development of strategies related to the detection of synthetic drugs of abuse.

NEW PLAN PRIORITY: Facilitate training programs for professional and nonprofessional personnel with respect to drug and alcohol abuse and dependence, including the encouragement of such programs by local governments.

DDAP offers a robust training program that includes courses for the professional and non-professional alike. These trainings are available through mini-regionals, regional training institutes, and on-sites. Specialty courses such as SBIRT, Women and Children Issues, FASD, STAR, Underage Drinking, etc. are offered depending on your area of expertise and DDAP encourages the development of new courses that may be offered in its curriculum. It is DDAPs belief that a well-educated workforce can best provide quality services in a cost efficient manner and thus improve outcomes for individuals impacted by drug and alcohol use.

By providing training to the community, DDAP has begun a commitment to provide knowledge and information to individual citizens who can impact substance abuse in their locality.

NEW PLAN PRIORITY: Support a system of collaborative emergency medical services for person's voluntarily entering treatment.

DDAP is committed to ensuring that all individuals seeking treatment are able to access them in a timely manner. Individuals in need of detox must be admitted to such services within 24 hours. When an individual is screened through the SCA system, emergent care needs that are identified must be addressed immediately. Emergent care needs consist of detoxification, prenatal care, perinatal care, and psychiatric care. Training is available in these areas through DDAP. Individuals seeking drug and alcohol treatment services may be assessed at detox facilities, hospitals, correctional facilities, and mental health facilities.

NEW PLAN PRIORITY: To gather and publish statistics pertaining to drug and alcohol abuse and dependence and promulgate regulations, specifying uniform statistics to be obtained, records to be maintained and reports to be submitted by public and private departments, agencies, organizations, practitioners and other persons with respect to drug and alcohol abuse and dependence, and related problems.

Through the use of the STAR and PBPS data systems DDAP gathers statistical information on the prevalence and incidence of substance use throughout the Commonwealth. DDAP has mandated certain information to be collected by the SCAs and their providers in compliance with federal reporting requirements. This information provides specific details related to gender, age, substance use, employment, education, criminal justice activity, referral source, marital status, etc., on individuals involved in the publically funding drug and alcohol service system. Reports can then be generated to give a snapshot of the status of drug and alcohol use within the state. The information obtained by DDAP is used to drive decision making relative to the drug and alcohol service system.

PRIOR PLAN PRIORITY: Increase the availability of Buprenorphine within the substance abuse treatment system.

The number of individuals dependent on heroin and other opiates continues to rise in Pennsylvania. Many Single County Authorities (SCAs) report that heroin/opiates are increasingly the drug of choice in the population they serve. In SFY 09-10 the SCAs provided Buprenorphine detox and maintenance services to nearly 500 individuals, and in SFY 10-11 the data indicates approximately 780 served.

An action memorandum describing the Buprenorphine Workgroup recommendations for expanding/modifying the exception to 28 Pa. Code Chapter 715 was sent to the Secretary of Health on January 19, 2012 for review and approval.

The Department continued to hold meetings of the Buprenorphine Workgroup, to: 1) monitor the response from the Secretary of Health to the action memorandum describing the Buprenorphine Workgroup recommendations for expanding/modifying the exception to 28 Pa. Code Chapter 715; 2) discuss implementation plans for approved parts of the action memorandum, as well as plan to evaluate the impact the changes have on delivery of Buprenorphine services; and 3) monitor progress on any recommendations made by the specific workgroups in regards to physician education/training, reimbursement and expansion of access to treatment services.

The Buprenorphine workgroup met most recently in May 2011. The discussion surrounding Physician Training/Education, Reimbursement, and Chapter 715 Regulations is summarized below. The workgroup can be convened to address these and/or other topics as needs arise and are deemed appropriate for discussion and action.

Physician Education/Training

Diversion and abuse are the most significant problems identified with Buprenorphine treatment. Education and training for physicians is viewed as the best way to minimize it. If convened, the Workgroup may consider the following issues: who could provide appropriate training, who would pay for it, what requirements would be included, how it might be implemented, and what effects it might have on malpractice insurance. The workgroup previously acknowledged that this issue will require careful consideration and some constructive input from members.

Reimbursement

DDAP and other Workgroup participants have established a closer working relationship with representatives of the Department of Public Welfare (DPW), Office of Medical Assistance Programs (OMAP). This relationship will continue to help facilitate the timely exchange of reimbursement-related information, and a better understanding of policies and procedures governing delivery of this service. An example of this collaborative benefit is the April 2010 OMAP presentation to the Workgroup on the Buprenorphine Prior Authorization Bulletin update of the Pharmaceutical Services Handbook section on Oral Buprenorphine Agents. In this setting, participants received updated information and were able to engage in dialogue with other members and the presenter, leaving with a clear and consistent understanding of this new information.

Chapter 715 Regulations

In May 2011, the Workgroup met to discuss Chapter 715 regulations for residential facilities, focusing on those sections of the Chapter that would be applicable for the

exception process, and areas that could possibly be removed from waiver coverage for outpatient facilities. It was noted that the Outpatient Waiver was requested and granted to improve access to treatment, but safety issues due to non-compliance with regulations are potentially causing problems. Now that many access problems have been eased, several members expressed the opinion that the Workgroup should revisit the regulations and discuss the improved safety that enforcement/revision may provide.

Also discussed was the potential need for "verbal orders" for short-term use of buprenorphine in a detoxification program during urgent situations (e.g., client presents for detox, and there is no physician on-site and a verbal order for buprenorphine is needed). Some Workgroup members want relief from the Chapter 715 regulation mandating that a physician must be present to prescribe buprenorphine. The issues of who might be qualified to evaluate the patient, what constitutes an "emergency," safety concerns, and other options besides buprenorphine were addressed. Workgroup members (physicians) agreed to draft guidelines/recommendations to possibly resolve this problem for residential facilities and provide them to the Workgroup for further discussion.

Specific Chapter 715 Regulations (currently in existence for **residential facilities** using buprenorphine) were identified as presenting *possible* obstacles to service delivery. It was felt that these regulatory obstacles would be best resolved by submitting a waiver for an exception. On January 19, 2012 the following regulations were approved for waiver under a facility-specific exception request: 715.14 Urine testing, 715.16 Take home privileges, 715.20 Patient transfers, and 715.24 Narcotic Detoxification.

Specific Chapter 715 Regulations were identified as needing ***increased*** enforcement /monitoring for **outpatient facilities** in the interest of client safety. On January 19, 2012, the following regulations were approved for restoration: 715.6 Physician Staffing, 715.9 Intake, 715.10 Pregnant Patients, 715.13 Patient Identification, 715.14 Urine Testing, 715.15 Medication Dosage, 715.19 Psychotherapy Services, 715.21 Patient Termination, and 715.28 Unusual Incidents.

On January 19, 2012, the following guidelines were approved, allowing a Buprenorphine Treatment Program (BTP) to receive verbal orders for buprenorphine for detoxification from a BTP physician during urgent situations in which delays in providing the treatment would put the patient at risk for a negative outcome.

1. Document psychological support given to patient.
2. Document effect of non-opioid medication, such as clonidine, on patient's condition.
3. Evaluate for need for opioid medication.
4. An assessment tool, completed by at minimum a registered nurse (RN), should include documentation of past and current drug dependency and treatment, drug use status and history, including any prescription medications, licit or illicit, that may be contraindicated for buprenorphine, completion of a withdrawal scale such as the Clinical Opioid Withdrawal Scale, urine toxicology results, biographical data, and health and illness patterns. The BTP RN, after reviewing the initial assessment, calls the BTP physician and reviews the assessment findings with the physician.

5. A verbal order for buprenorphine should not be given unless the following three criteria are met:
   - The patient must be physiologically dependent on opioids and experiencing significant withdrawal symptoms that potentially put the patient at risk for a negative outcome;
   - The BTP staff concludes that there is no appropriate alternative treatment other than buprenorphine available to adequately stabilize the patient; and,
   - There is no significant sedative-hypnotic physical dependence present. If the patient is dependent on alcohol or other sedative-hypnotics, such as benzodiazepines, the patient must be assessed personally by the physician.
6. The BTP physician approves or disapproves administration of Buprenorphine. If a verbal order is given, the physician determines the initial dose. Only a single dose, or a dose divided in two, may be ordered verbally, and the verbal dose may not exceed 8 mg.
7. The BTP physician MUST see the patient within 24 hours and sign off on the verbal medication order.

Each program would need a written protocol to detail who (e.g., minimum of a RN) can complete the assessment. Also within the protocol, the program should state which instruments will be used for the various parts of the evaluation and what scores on the various instruments would make a patient eligible or ineligible for an immediate buprenorphine order. The physician would need to co-sign the various assessments when s/he signs the verbal order.

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While increasing the availability of buprenorphine is no longer a priority the Department plans to continue holding meetings of the Buprenorphine Workgroup, to: 1) monitor the impact the changes approved in the action memorandum have had on delivery of Buprenorphine services; 2) monitor progress on any recommendations made by the specific workgroups in regards to physician education/training, reimbursement and expansion of access to treatment services; 3) discuss any emerging issues surrounding Buprenorphine including diversion and linkage to treatment. There are 15 SCAs currently approved to pay for Buprenorphine services.

PRIOR PLAN PRIORITY: Increase access to substance abuse treatment and recovery support services through the expansion of consumer choice and increase service capacity through a network of community and faith-based providers within the Philadelphia service region through implementation of the Access to Recovery (ATR) grant.

Access to Recovery (ATR) is a four year, federal, discretionary grant that was awarded to the Department and its project partner, Philadelphia SCA, in 2010. The project supports SAMHSA's initiatives to build capacity for the delivery of services, both treatment

and recovery support services at the community level, thus providing individuals with access and choice. These concepts are foundational to ROSC and recovery principles. As research continues to be done on successful recovery maintenance, the delivery of services through a ROSC is being substantiated as both supportive of recovery and cost effective. The ATR program is assisting Philadelphia with its implementation of ROSC. It is hoped that lessons learned from the project might be useful for system implementation elsewhere in the state.

ANNUAL REPORT FY 2011-12

In September 2010, the Department was awarded a four year grant totaling $11,889,262 for the period of September 30, 2010 to September 29, 2014 from the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) to implement an Access to Recovery (ATR) program in Philadelphia County. The focus of the grant is to expand access to recovery through the provision of an array of treatment and recovery supports at the local level by traditional, as well as faith-based and grass root organizations in its provider network, with an emphasize on participant choice. The grant requires a specific number of clients to be served with the designated annual funding amounts which vary for each year of the project. Funding by year for the four year project includes $2,617,201 for the first year which began September 30, 2010 and ended September 29, 2011. The project received continuation funding for the second year which included $3,249,418 from September 30, 2011 through September 29, 2012. Continuation funding for the third year was secured in the amount of $3,221,322 for the period of September 30, 2012 through September 29, 2013. If the project continues to be funded, the fourth year would include $2,801,321 from September 30, 2013 through September 29, 2014. Throughout the entire four year project 10,705 clients will receive ATR services with this grant funding.

The Department partnered with the Philadelphia Single County Authority (SCA) which is the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Office of Addition Services (OAS) to implement this four year project. The project was designed to provide uninsured or underinsured adults with alcohol or other drug challenges with an array of options and choices of providers to obtain clinical treatment and enhanced recovery support services through a voucher system. Within the uninsured or underinsured target population, the project prioritized several sub-populations for inclusion through specific eligibility criteria which includes people experiencing homelessness, individuals re-entering society from the criminal justice system, pregnant or parenting women, and veterans.

The project was fully operational on January 31, 2011 as required by the notice of grant award. During the initial implementation period the project focused on staff and provider recruitment and training, client enrollment and enhancements to the voucher management system (VMS). The provision of recovery support services continued to be the key focal point during the year. These services were aimed at helping individuals engage in recovery, enable them to obtain or remain in treatment, help them transition their lifestyles away from addiction and provide recovery coaching to maintain a life in recovery.

During the second year, the SCA provider network was expanded to 57 recovery support service providers; 22 of which are ATR evaluation sites. This expanded provider

network is comprised of additional faith-based and community-based providers aimed at reaching individuals that might not otherwise receive treatment or recovery support services. This expansion facilitated the inclusion of additional recovery support services which currently includes an assortment of fifteen services. In addition, unexpended funds from the first year were transferred to the second year via an approved carryover plan, thus facilitating new service categories including: Enhanced Educational Support, Employment/Vocational Training Expansion, and Clinical Assessments in non-traditional settings. Also during the second grant year, project advancements were made to improve training and service structures, voucher and fiscal management, assertive outreach and engagement as well as collaborative partnership development.

PROGRESS REPORT FY 2012-13

The Department continues to work closely with ATR project partners including the Philadelphia SCA and the VMS vendor Knowledge Information Technology (KIT) Solutions to maintain project services. The project is also working on sustainability strategies in an effort to continue services beyond the four year grant funding period. The annual client target was exceeded in both the first and second years of the project.

During the second year of the project which began September 30, 2011 and ended September 29, 2012, a total of 4,992 individuals were enrolled for ATR services, exceeding the annual target of 3,642. This represents an Intake Coverage Rate of 137%. In the past year, the provider network has expanded from 48 evaluation and recovery support service providers to 57, including 20 faith-based organizations and 37 community-based providers. In addition, the number of Recovery Support staff has increased to 24, more than doubling that which was proposed in the original grant application. The increases to providers and staff represent an increased capacity to enroll and provide services to individuals that might otherwise not receive treatment or recovery supports. As of December 2012, 751 new client intakes of the 3,542 Year 3 annual target have been completed, with a total of 7,125 unduplicated persons being served by the project to date. The program is on target for meeting its overall goal of serving 10,705 individuals over the 4 year span of the project.

While these numbers are significant, the outcomes realized by those participating in the project are also substantial program accomplishments. Of the 6 Month Follow Up data, some of the most notable includes: 91.1% of individuals remained abstinent, 99% had no arrests in the prior 30 days, 24.4% were currently employed or attending school (representing a 103.7% change rate), and 27.9% (125.2% change rate) of participants reported having a permanent place to live in the community.

ATR continuation grant funding for the third year was secured in July 2012. The third year of the project began September 30, 2012 and progress is underway for achieving the target of providing ATR services to 3,542 unduplicated individuals. In addition, an upload tool is currently under development to enable the inclusion of treatment service data in January 2013.

WOMEN AND CHILDREN'S ANNUAL REPORT (as required by Act 65 of 1993) STATE FISCAL YEAR 2011-12

Act 65 of 1993 authorizes the DOH to establish and fund residential drug and alcohol treatment programs for pregnant women and women with dependent children. This responsibility was transferred to DDAP pursuant to Act 50 of 2010. The Department contracts with Single County Authorities (SCAs) who authorize expenditure of the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant allocations for Women with Children and Pregnant Women to include all levels of care that offer specific services to this population. Such services are SAPT Block Grant requirements.

Consistent with that mandate, the Department has developed programs designed for women accompanied by their children. In addition to therapies dealing with substance use disorders, the women and children programs offer training in parenting, social and life skills development, family therapy or family reunification and other activities related to their rehabilitation. Children are given age appropriate education regarding substance abuse, and, if school age, they are enrolled in a nearby school. Women and children programs across the Commonwealth have worked diligently to establish a positive working relationship with staff from the local school districts so that the children are served in the best possible way. Additionally, programs across the continuum of care have been developed within individual SCAs by willing providers that offer similar services at a level of intensity appropriate to individual types of service.

During the course of FY 2011-12, service capacity for women and women with children was as follows (Note: The following numbers are conditional upon space and the number of people residing at each facility at any given time):

Programs providing residential treatment services exclusively for pregnant women or women with dependent children = 16

Total Capacity for Women = 263
Total Capacity for Children = 452

Residential Programs for Women = 13

Total Capacity = 228

Transitional Living Facility Program = 1

Total Capacity = 12

Halfway House Programs = 16, one of which allows women to bring their children

Total Capacity for Women = 347

Total Capacity for Children = 28

SCAs are contractually required to provide access to a full continuum of care and provide preferential services for this population. As a result, a number of treatment providers have developed gender-specific components to existing programs that serve the needs of this population either on-site or by referral to appropriate agencies. Age-appropriate prevention programs for the children of women in treatment are provided, as well through agreements with prevention providers or specially trained child development staff.

Expected outcomes for women-centered and need-specific programming for women and children include:

- Development of knowledge and skills to maintain a self-directed recovery and abstinence from alcohol and other drugs;
- Education and life skills to become productive members of society;
- Prevention and education for accompanying children;
- Reduction in perinatal addictive disorders;
- Reduction in acute health care costs;
- Reduction in legal system involvement and criminal behavior;
- Reduction in unemployment;
- Reduction in homelessness;
- Development of parenting skills for mothers; and,
- Improved communication skills for mothers and children.

During FY 2011-12, the following residential women with children programs were in operation:

- Family Links, Inc. in Allegheny County
- Family Links, Inc. in Fayette County
- Family Links - Family Treatment Center Frankstown in Allegheny County
- Gaudenzia, Inc. - Fountain Springs in Schuylkill County
- Gaudenzia, Inc., Vantage House in Lancaster County
- Gaudenzia, Inc. Winner Co-occurring Women and Children Program in Philadelphia County
- Gaudenzia Kindred House in Chester County
- Gaudenzia New Image in Philadelphia County
- Genesis II, Inc. DBA Caton Village in Philadelphia County
- Interim House West in Philadelphia County
- Libertae Family House Libertae, Inc. in Bucks County
- My Sister's Place, Thomas Jefferson University in Philadelphia County
- RHD Family House in Montgomery County
- RHD Family House NOW (New Options For Women) in Philadelphia County
- Samara House of CYWA in Chester County
- Sojourner House, Inc. in Allegheny County

In addition, there were 16 halfway house programs that specifically provided services to women. Some of these facilities can accommodate pregnant women and two facilities are able to accommodate women with their children:

- Abstinent Living at the Turning Point at Washington, Inc. in Washington County
- Another Way in Fayette County
- Catholic Charities Diocese of Harrisburg, PA, Inc. (Evergreen House) in Dauphin County
- Clem-Mar House, Inc. in Luzerne County
- Cove Forge Renewal Center in Cambria County
- Gaudenzia - New Destiny in Schuylkill County
- Gaudenzia Erie Inc., Community House in Erie County
- Libertae, Inc. in Bucks County
- Pyramid Healthcare – Belleville in Mifflin County
- Pyramid Healthcare, Inc., Pine Ridge in Pike County
- Pyramid Healthcare, Inc., Tradition House in Blair County
- PA Organization for Women in Early Recovery (POWER) in Allegheny County
- The Gate House for Women in Lancaster County
- The Highland House, Inc. in Lawrence County
- The Lighthouse for Women of Greenbriar Treatment Center in Washington County
- Myah's House of Hope in Armstrong County

There was one licensed transitional living facility which specifically provided services to women.

- Next Step Foundation, Inc. in Allegheny County

There were thirteen facilities across the Commonwealth that provided residential treatment programs for women:

- Clem-Mar House, Inc. in Luzerne County
- Eagleville Hospital in Montgomery County
- Gaudenzia, DRC, Inc. in Philadelphia County
- Gaudenzia Together House in Philadelphia County
- Greenbriar Treatment Center in Washington County
- Interim House, Inc. in Philadelphia County
- Mary E. Steratore Addiction Treatment Center in Fayette County
- Mirmont Treatment Center in Delaware County
- RHD – Womanspace in Montgomery County
- RHD – Womanspace in Philadelphia County
- Roxbury in Cumberland County
- Turning Point Chemical Dependency Treatment Center (Freedom Center) in Venango County
- UHS Recovery Foundation, Inc. (dba Keystone Center) in Delaware County

The Department continued to support the provider organization, Women and Their Children Heal (WATCH). WATCH consists of residential and outpatient treatment providers statewide who provide drug and alcohol treatment services to women, pregnant women and women with children, particularly serving women within a gender-specific model of care. Their mission is the enhancement of gender-specific drug and alcohol programs and the protection of mandated services for women, pregnant and parenting women and their children. Department staff continued to serve as a liaison to WATCH, attended meetings,

provided administrative support and facilitated collaboration between this group and other state agencies. The Department continued to utilize this group's expertise as a resource as they provided feedback regarding the provision of women's treatment services, best practices, provider education and other needs facing this population. WATCH developed a training comprised of best practices for the provision of treatment services to women. During the state fiscal year, this gender-responsive training entitled "Gender-Responsive: Treatment that Matters for Women with Substance Use Disorders," was finalized, approved for inclusion into the Department's training management system, and officially rolled out at the regional training institute in October 2011 in Pittsburgh. The Department will continue to provide technical assistance to WATCH as they continue to facilitate this training throughout the Commonwealth and modify the curriculum as needed. The Department will continue to support WATCH and utilize this resource to ascertain feedback relative to women's treatment services, best practices, provider education and other needs facing this population.

In addition, the Department continued to host the Women's Treatment Forum, a venue designed to educate and inform drug and alcohol treatment providers about the current gender-specific needs and issues surrounding the women they serve as well as possible resources to assist with such practices. It is an opportunity to bring treatment providers together annually to discuss women-centered and need-specific programming for women and children, as well as share best practices for the provision of treatment services to women. This year's event included two renowned guest speakers. The first was Heidi O'Toole, an author and motivational speaker, who presented information about ways to develop effective parenting and relationship skills. The second was singer, song-writer, activist, and author Judy Collins who shared her personal story of recovery and how she overcame substance abuse and depression. Plans are underway for the upcoming women's treatment forum to occur in May 2013.

PROGRAM MONITORING

BACKGROUND

The Department of Drug and Alcohol Programs (DDAP), Bureau of Quality Assurance for Prevention and Treatment, Evaluation and Contract Compliance (Division) has the primary responsibility to oversee the Single County Authorities' (SCAs) adherence to grant agreement requirements and to evaluate the SCAs' efficacy in carrying out their administrative functions, while efficiently managing all available resources at the local level. The Division conducts annual Quality Assurance Assessments (QAAs) of the SCAs. The QAA process is designed to assess the SCAs administratively, fiscally and programmatically.

Administratively, the review consists of the following major elements: service coordination contracts with funded organizations, continuum of care verification, community representation on the local advisory council, insurance coverage and fiscal structure, timeliness of required reports, subcontractor work statements and the performance monitoring of the providers of service. Internal fiscal reviews by DDAP's Fiscal Section, in collaboration with Division staff, occur throughout the fiscal year and provide a close inspection of fiscal reports and budget information associated with Department dollars.

Programmatically, the QAA process: 1) ensures that the local drug and alcohol service delivery system is a quality system; 2) addresses emergent care needs; 3) ensures timely access to assessment and treatment services; appropriately utilizes the Pennsylvania Client Placement Criteria (PCPC) for level of care determinations, continuing stay reviews and discharge planning; 4) verifies availability of case management services; 5) provides a quality review of performance-based prevention activities; and 6) ensures the implementation of Federal Block Grant requirements. The Federal Block Grant requirements include, but are not limited to, provisions for interim and ancillary services, capacity management and outreach efforts, all of which are designed to increase services to the identified priority populations of pregnant women and injection drug users.

PAST PRIORITY: On-site Quality Assurance Assessment Review Monitoring of Single County Authorities (SCAs).

ANNUAL REPORT FY 2011-12

The Department's five-year grant agreement began July 1, 2010. The Division began onsite monitoring of all 47 SCAs on the new requirements in April 2011. For FY 2011-12 the Division began onsite monitoring of all 47 SCAs in March 2012. The Department has moved to a 12-month monitoring process incorporating the annual onsite review with an in-depth interoffice review to verify adherence to Department grant agreement requirements throughout the rest of the grant agreement. DDAP continued to focus the review from a management perspective, as well as adherence to compliance of the grant agreement requirements.

PROGRESS REPORT FY 2012-13

In October, 2012, the Division completed the monitoring review process of all SCAs that began in March 2012. The Division met with Department management to work toward enhancing the FY 2012-13 annual monitoring process to not only review compliance with Grant Agreement requirements, but to also evaluate the overall effectiveness of the SCA's management of the service delivery system. The purpose of the on-site portion of the QAA process which is scheduled to occur between June and September, 2013 will focus primarily on ensuring timely access to, and retention in, the appropriate level of service. In addition, the Division will review the SCA's process for tracking of funding sources and payment to providers. In order to make effective use of the amount of time spent on-site, the Division incorporated the use of pre-submitted materials, conference calls, technical assistance, and in-house review and evaluation.

Drug and Alcohol Program Licensure

The Division of Drug and Alcohol Program Licensure in the Bureau of Community Program Licensure and Certification is responsible for licensing free-standing drug and alcohol treatment facilities. These responsibilities are carried out pursuant to the powers and duties contained in Articles IX and X of the Public Welfare Code (62 P.S. §§ 901-922, 1001-1059), as transferred to the Department by Act 50 of 2010.The Division is responsible for the licensure of any partnership, corporation, proprietorship, or other legal entity intending to provide drug and alcohol treatment services. The Department has regulatory responsibility through its licensure authority over both public and private drug and alcohol treatment facilities.

Drug and alcohol treatment activities which are a part of a health care facility are also subject to the requirements for a health care facility under 28 Pa. Code, Part IV. The health care facility receives a license under the Health Care Facility Act, 35 P.S. § 448.101 *et. seq.*, which covers the general operations of a health care facility. The Department also issues a certificate of compliance to the drug and alcohol component within the health care facility which certifies that program areas meet the minimum standards germane to drug and alcohol treatment under the Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. §§ 1690.101-1690.115).

Facilities which use methadone in the treatment of narcotic abuse are subject to the regulations in 4 Pa. Code, Chapter 715 and must be approved by the Department.

NEW PRIORITY: To provide standards for the approval by the relevant State agency for all private and public treatment and rehabilitative facilities.

DDAP continually reviews policies, procedures, and regulations to determine their effectiveness in providing and implementing quality and evidence based programming. The DDAP has worked with provider associations to review regulations and offer recommendations to help reduce redundancy and administrative burden while still ensuring that quality services are provided in a safe and confidential manner.

PROGRESS REPORT FY 2012 -2013

Licensing standards and regulations exist for those facilities that provided drug and alcohol treatment within the Commonwealth.

The Department of Drug and Alcohol Programs (DDAP), Bureau of Quality Assurance for Prevention and Treatment, Division of Program Licensure, is responsible for ensuring that facilities providing drug and alcohol treatment services meet minimum standards of safe and quality care based on the current regulations.

DDAP, recognizing that facilities may undergo multiple inspections throughout the year, is working to reduce the administrative burden and redundancy experienced by the providers. DDAP has been reviewing relevant regulations, along with feedback from

community providers to develop changes that will streamline regulations, the inspection process and reduce redundancy.

Bureau of Quality Assurance, Overview of reviews YTD

Requests for applications/standards processed	139
Initial and renewal licensing inspections conducted	690
Incident reports received and evaluated	708
Complaints investigated	71
Presurvey Manuals Reviewed	619
Narcotic Treatment Program monitoring inspections conducted	93
Plan of Correction follow up inspections conducted	183
New licensing applications processed	35
Incident report follow up conducted	7
Ownership changes processed	42

NEW PRIORITY: To provide grants and contracts to local governments and public and private agencies, institutions and organizations for the prevention, intervention, treatment, rehabilitation, research, education and training aspects of substance use disorders.

DDAP contracts with the SCAs for the provision of prevention, intervention, treatment, and recovery services in their respective communities. DDAP also provides funding to various entities throughout the Commonwealth for treatment, prevention, recovery, education and training related services. These agencies include PRO-A, DOC, DPW, and Gaudenzia, Inc. Additionally, DDAP partners with local agencies for the administration of federal discretionary grants that it receives such as the Access To Recovery (ATR) and the Strategic Prevention Framework-State Incentive (SPF SIG) grants. DDAP issues Requests for Proposals and reviews these requests for funding and issues awards as deemed appropriate.

DDAP also monitors for federally funded and other grant opportunities which could be sought to increase funding and collaboration with community partners. DDAP has supported PCCD granting of funds to the Pennsylvania District Attorney's Association to increase the availability of permanent drug take-back repositories. DDAP has submitted applications for a range

TRAINING

BACKGROUND

The Department of Drug and Alcohol Programs' (DDAP) training system provides continuing education and skill-building courses in order to meet the needs of the substance abuse and problem gambling fields. These courses focus on state-of-the-art concepts presented by experts and practitioners in the substance abuse and problem gambling treatment and prevention fields and other ancillary fields. DDAP has an extensive list of skilled trainers able to conduct trainings throughout the Commonwealth. The major components of the training system are:

Mini-Regional Trainings

The Mini-Regional Trainings (MRTs) are one-day events containing up to four core or basic courses. The MRTs are offered every other month in each of the six health districts. The courses are rotated through each of the health districts, providing each district with up to 24 courses per year. There is no charge for participation in the MRTs.

On-Site Trainings

The on-site trainings allow service providers and SCAs the opportunity to request trainings specific to their needs at little or no cost to the requestor. All requests for on-site training must be coordinated through the respective SCA to ensure maximum use of the training site and trainer.

Specialized Trainings

These trainings usually address new initiatives or changes in policies or practices. These trainings are often initiated by DDAP and are usually mandatory. They may also include courses that do not have sufficient attendees in any one specific area of the Commonwealth. These courses will be centralized and presented as a specialized training.

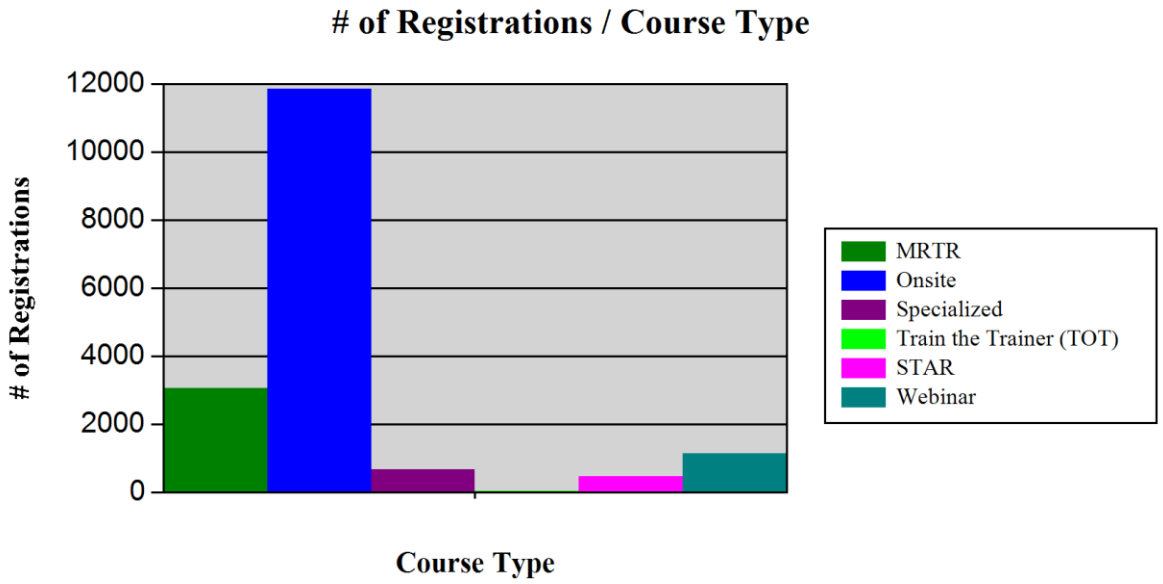
Regional Training Institutes

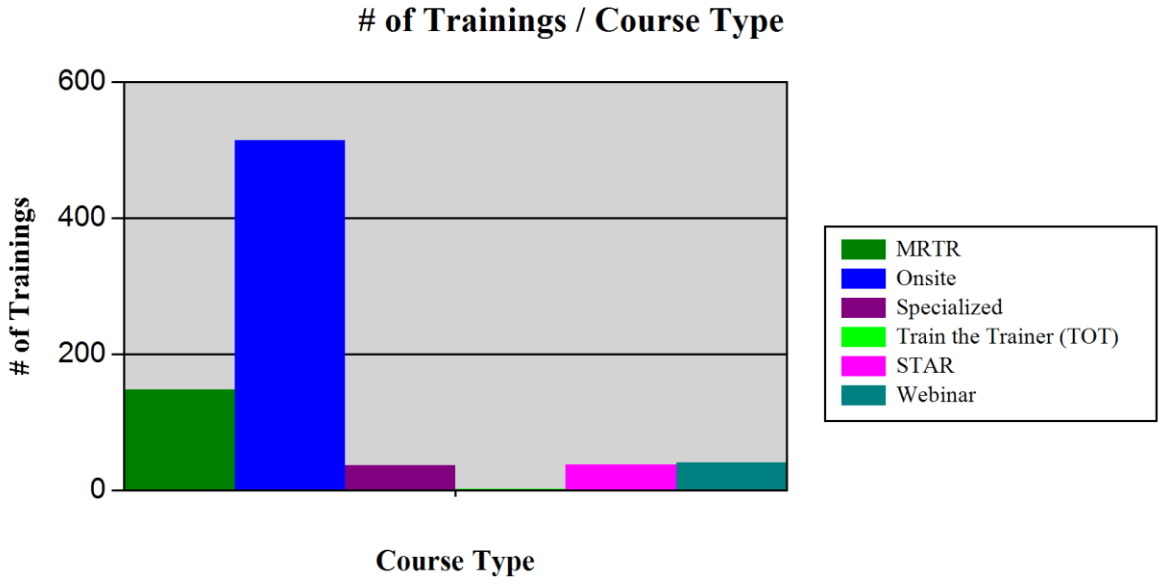
The Regional Training Institute is a five-day event designed to offer higher level courses to the substance abuse field. This event is held once each year. As with all our trainings, courses offered in the Regional Training Institutes offer Certified Addiction Counselor and NASW credits so that employees can maintain their PCB and/or NASW certifications. There is no charge for participation in the Regional Training Institutes.

Public Health Information Clearinghouse

The Information Clearinghouse provides, upon request, information on a wide variety of public health issues. Materials are provided and shipped free of charge. The clearinghouse catalog is available online at www.health.state.pa.us/padohric/.

COURSE REGISTRATIONS AND TRAININGS 2011-2012





DATA

BACKGROUND

The ultimate goal of the any performance management process* is to use quantifiable data to strengthen the quality of any system, thereby improving outcomes.. This process guides decision makers to identify and track health-related benchmarks, as well as indicators of the quality of care and appropriate health outcome indicators. When well-supported and appropriately implemented, a performance management process can improve the quality of the health care system over what might be attained by traditional management methods. Our systems should be used to identify areas of exemplary performance, which can lead to sharing information about effective practices. Public accountability is enhanced by ongoing efforts to monitor data to improve services.

PAST PRIORITY: Improving public health through the identifying, tracking and evaluating key health indicators and the reporting of those metrics.

As the Single State Agency for drug and alcohol funds in Pennsylvania, the Department is uniquely positioned to infuse performance management throughout the system to improve the quality of services, client satisfaction and outcomes. Current State data systems provide a foundation on which to build a performance management approach to improving treatment results.

The Department maintains drug and alcohol data as a routine part of our operations. Treatment data was collected through the Client Information System (CIS) until June 2012. Beginning in July 2012 all treatment data is being collected in our new multitier treatment framework dubbed STARS (Strengthening Treatment and Recovery System). All prevention data is collected through Performance Based Prevention System (PBPS). Pursuant to the federal obligation for receipt of the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) from the Substance Abuse Mental Health Services Administration (SAMHSA), national outcome measures (NOMs) related to the prevention and treatment of substance abuse disorders are reported to SAMHSA. NOMs measures include, but are not limited to: abstinence from drug and alcohol use, increased school attendance and employment, cost effectiveness, etc. Much of the data currently collected provides basic information on the number of services, number of people served and the types of services provided.

The Department's Data Section has been actively involved in shaping the NOMs discussion, as well as looking to develop additional measures that the state will use to gauge the effectiveness in its ever evolving statewide treatment and prevention systems. The Department in conjunction with the Institute of Research, Education and Training in Addictions (IRETA), defined state performance-based measures in 2004. These measures, as well as new treatment NOMs, will soon be available via the successful data capture from STARS. The Data Section also provides Government Performance and Results Act (GPRA) oversight to the Access to Recovery Grant. Other important areas of involvement include Prevention NOMs and an expansion of our prevention accountability through data reporting, fulfilling the SAPT Block Grant data reporting, updating information to the Federal Drug and

Alcohol Services Information System (DASIS) Treatment Episode Data Set reporting and maintaining DDAP's portal website and list serve communications.

***** (*As used in this document, performance management refers to the process of using performance measures and other data to improve the efficiency and effectiveness of organizations (Landrum & Baker, 2004). Performance measures are quantitative indicators that have been identified by program administrators as valid and reliable measures of program success or program difficulties.*)

Part 2: Program Data and Financial Information

Data Analysis Compiled from the Performance Based Prevention System (PBPS)
State Fiscal Year 2011-2012

To help Pennsylvanians lead healthier and longer lives, the Department promotes a structured, community-based approach to substance abuse prevention through prevention and intervention policies and practices that are based on the latest research within the substance abuse field. The framework aims to promote youth development, reduce risk-taking behaviors, build assets and resilience and prevent problem behaviors across the individual's life span. This report approach provides information that can be used by communities to build an effective and sustainable prevention infrastructure. The following tables and graphs are an analysis of that information.

Prevention Services in Pennsylvania

In Figure 1, Total Prevention Services are shown for all services reported through the PBPS. State Fiscal Year 2011-2012's increase of 2,213 services overall is mainly attributed to an increase in additional recurring services across Pennsylvania. Providers of these prevention services are becoming more efficient with delivery of both recurring and single services.

Prevention Services by Single and Recurring Type

Figure 2 details all single and recurring services across the state with the move towards a more recurring reinforcement approach to service delivery. This increase in the number of recurring services is in part due to a more defined policy requirement, specifically, 20 % of all prevention services provided must be recurring in nature. Research shows that prevention programs are best when implemented long-term with repeated interventions. Figure 2 shows that single services have stabilized and recurring services have increased over the last five State Fiscal Years (SFYs). Figure 3 further illustrates this change in policy by showing the number of people served in single services (attendees) and recurring services (participants). In the SFYs following the new policy, total attendees and total participants numbers have been increasing steadily.

The following defines single and recurring services:

- **Single Service Type** – Single prevention services are one-time activities intended to inform or educate general and specific populations about substance use or abuse (examples: Health Fairs, Speaking Engagements).

- **Recurring Service Type –** Recurring prevention services are a pre-planned series of structured program lessons and/or activities. These types of services are intended to inform, educate, develop skills and identify/refer individuals who may be at risk for substance use or abuse. A recurring prevention activity needs to have an anticipated measurable outcome, which may include pre- and post-testing (examples: Classroom Education, Peer Leadership Programs, Peer Mentoring, Alcohol, Tobacco and Other Drug (ATOD) Free Activities Recurring).

Figure 1

Total Prevention Services as Reported to PBPS State Fiscal Years 2007-2008 through 2011-2012

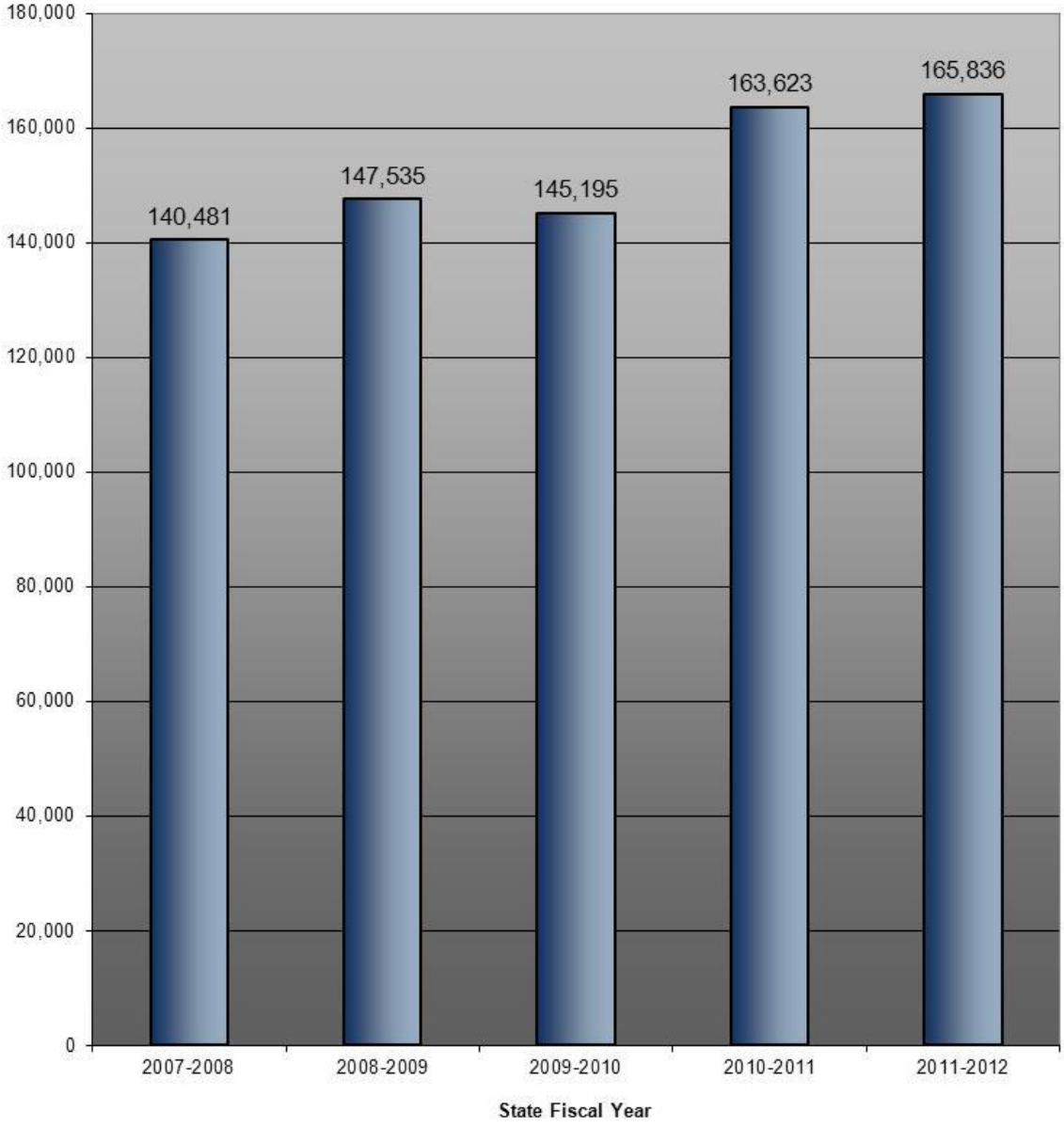


Figure 2

Single and Recurring Prevention Services as Reported to PBPS State Fiscal Years 2007-2008 through 2011-2012

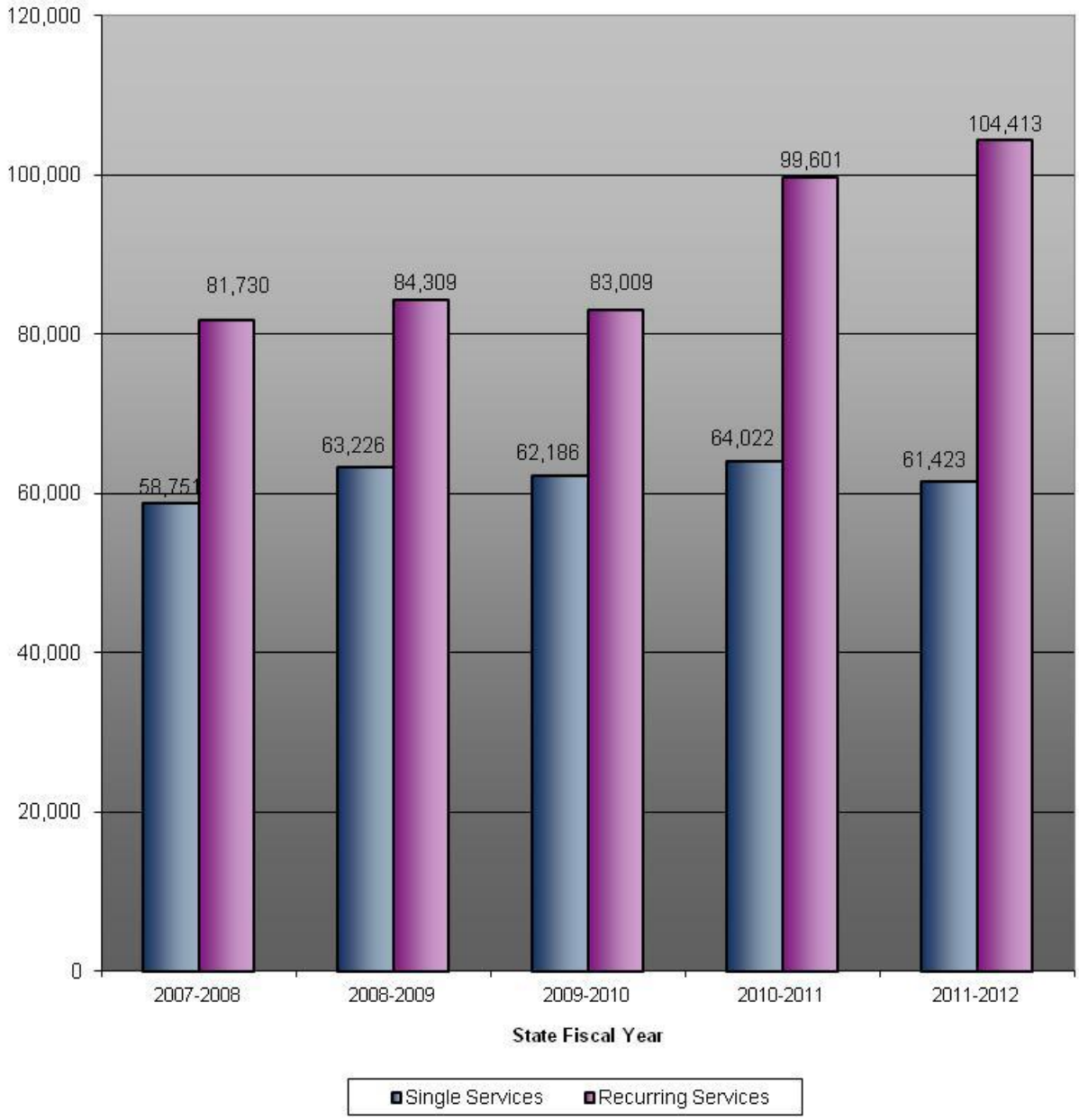
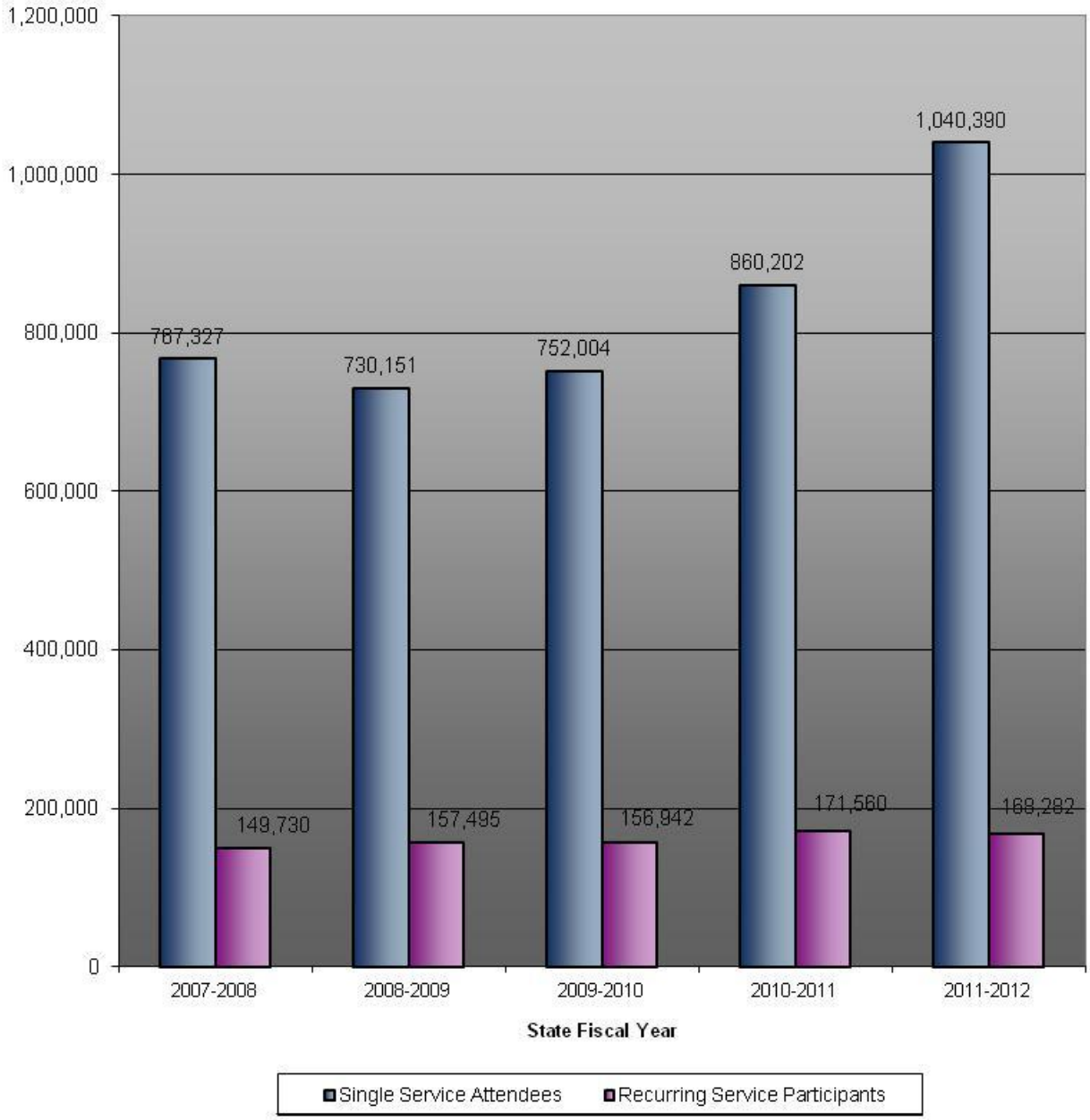


Figure 3

Prevention Service Attendees and Participants State Fiscal Years 2007-2008 through 2011-2012



Evidence-based Programs, State Approved Programs, and State Approved Strategies

The graph in Figure 4 demonstrates a five-year trend of the three prevention service categories: Evidence-Based Programs, State Approved Programs, and State Approved Strategies. In a move towards a more accountable approach, the Department required a minimum of 25% of services through Evidence-Based Programs and State Approved Programs. There has been an increase in Evidence-Based and State Approved Program services. Evidence-Based and State Approved programs provide more rigor and effectiveness than State Approved Strategies.

The programs are defined as follows:

Evidence-Based Programs include strategies, activities, approaches and programs which are:

- Shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse.
- Grounded in a clear theoretical foundation and carefully implemented.
- Evaluation findings have been subjected to critical review by other researchers.
- Replicated and produced desired results in a variety of settings.

State Approved Programs meet the following criteria:

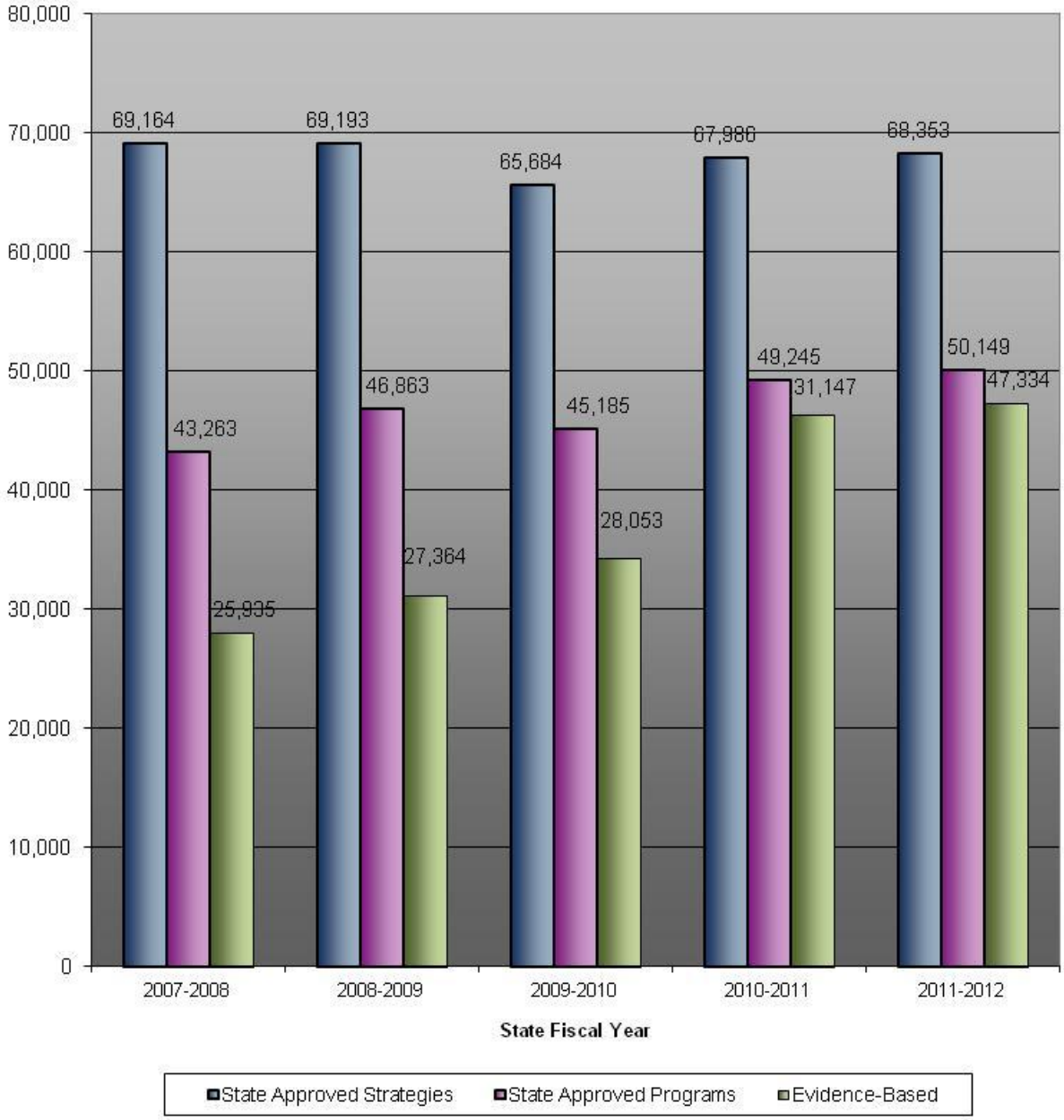
- Program/principle has been identified or recognized publicly and has received awards, honors or mentions.
- Program/principle has appeared in a non-referred professional publication or journal.
- Programs/Principle must have an evaluation that includes, but is not limited to, a pre/post test and/or survey.

State Approved Strategies are defined as programs which:

- Capture activities that utilize methods of best practice.
- Provide basic alcohol, tobacco and other drug awareness/education, as well as everyday alternative prevention activities.
- Captures strategies that address population-level change.
- Captures activities necessary to implement or enhance evidence-based and state approved programs.

Figure 4

Prevention Services by Program Category as Reported to PBPS State Fiscal Years 2007-2008 through 2011-2012



Institute of Medicine (IOM) and Prevention

In 1994, the Institute of Medicine (IOM) developed a model to show the effectiveness of a continuum of care. The IOM model includes three prevention classifications based on the degree of risk factors in the target population: universal, selective and indicated**.** They are defined as follows:

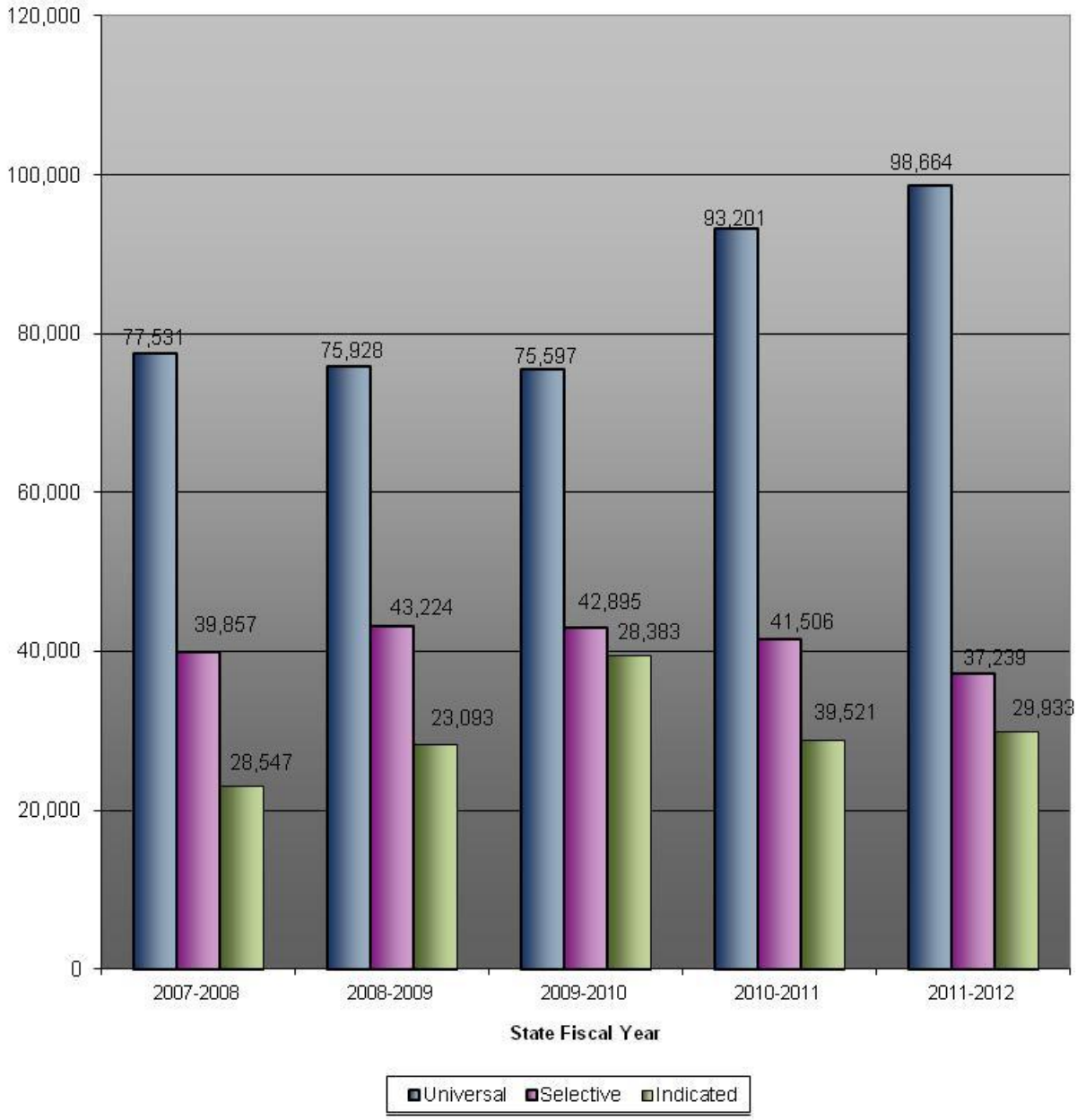
- Universal strategies address the entire population.
- Selective strategies focus on subsets or subgroups of the population exposed to greater levels of risk.
- Indicated strategies are designed to prevent the onset of substance abuse in individuals who have initiated the use of alcohol or other drugs.

These classifications were adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Substance Abuse Prevention and the Centers for the Application of Prevention Technologies.

Figure 5 shows a five-year trend of reporting data under the IOM classifications. The trend data shows Universal populations with an increase of 5,463 services from SFY 2010/2011. Services to Indicated populations also increased from 2010/2011 to 2011/2012, but services to Selective populations decreased.

Figure 5

Prevention Services by Institute of Medicine Population Categories as Reported to PBPS State Fiscal Years 2007-2008 through 2011-2012



pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

Figure 6 demonstrates a five-year trend of the six Federal Strategies. They are comprised of the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs. There has been a slight increase in the Community-Based Processes indicating a more holistic approach.

The six Federal Strategies are defined as:

- **Information Dissemination** – provides awareness and knowledge on the nature and extent of alcohol, tobacco and drug use, abuse and addiction and the effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

- **Education** – involves two-way communication, which is distinguished from the Information Dissemination category by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this category are to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.

- **Alternative Activities** – operates under the premise that healthy activities will deter participants from the use of alcohol, tobacco and other drugs. The premise is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol, tobacco and other drugs (ATOD) and therefore minimize or eliminate use of ATOD. These activities must be directly linked to an educational or skill-building activity.

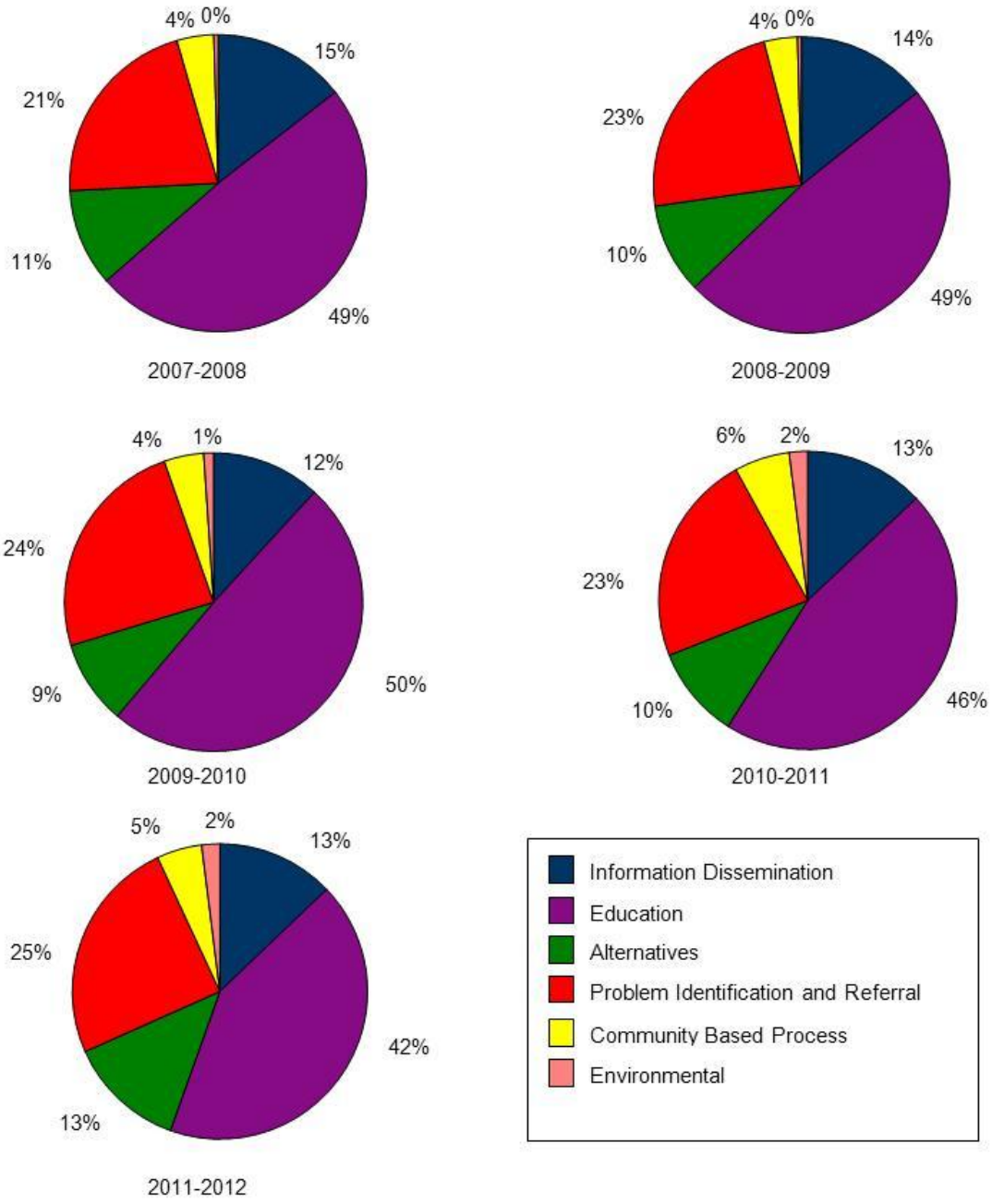
- **Problem Identification and Referral** – targets those persons who have experienced illicit/age-inappropriate use of alcohol, tobacco or other drugs in order to assess if their behavior can be reversed through education.

- **Community-Based Process** – aims directly at building community capacity to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services, inter-agency collaboration, coalition building and networking.

- **Environmental** – establishes or changes written and unwritten community standards, codes, ordinances and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the population. This category is divided into two subcategories: activities which center on legal or regulatory initiatives and those that relate to action-oriented initiatives.

Figure 6

Prevention Services by Federal Strategy as Reported to PBPS State Fiscal Years 2007-2008 through 2011-2012



IOM Population Categories

The six Federal Strategies are applicable and are utilized by each IOM population category. Figure 7 shows these population categories broken out by Federal Strategy for state fiscal year 2011-2012. Defined below are the three IOM population categories. Included in the definitions are examples of activities that comprise the overall concept of services that prevent or reduce the use and abuse of alcohol, tobacco and other drugs. While Education services play a large role in all Universal prevention service activities to large diverse groups, the indicated target population covering high-risk individuals is now showing over 50% Problem Identification and Referral services. .

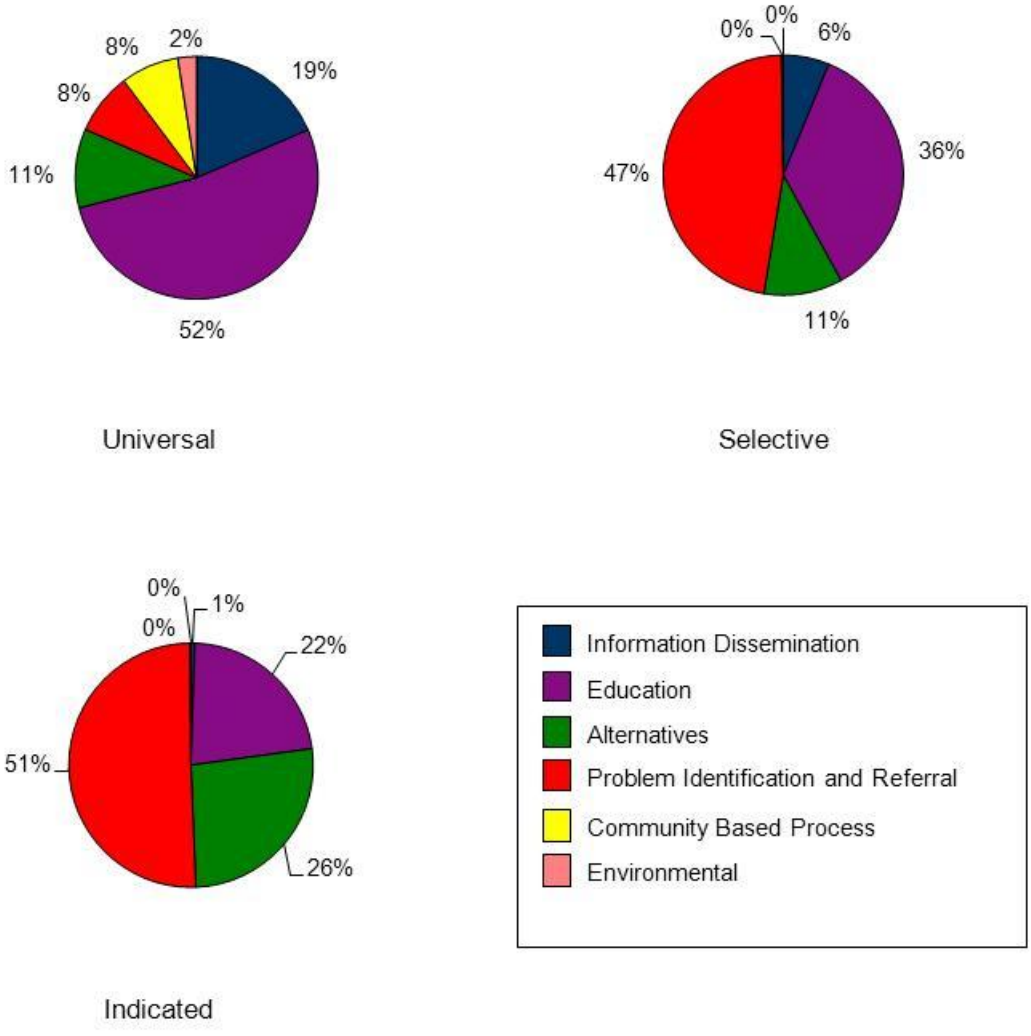
Universal Preventive Interventions are activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk. Information Dissemination is a large part of informing large general audiences successfully. Education to the universal population is also an important aspect of prevention programming. The Division of Prevention has the goal of increasing Community-Based Processes.

Selective Prevention Interventions are activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than the universal population. Education and Problem Identification/Referral are a large part of successfully providing service to this audience at this stage. Problem Identification/Referral is used with this higher risk population to get them into more intense prevention services. Continuing to provide this sensitive balance of services to meet this population's need is our goal.

Indicated Preventive Interventions are activities targeted to individuals in high-risk environments identified as having minimal but detectable signs or symptoms foreshadowing a disorder or having biological markers indicating predisposition for a disorder, not yet meeting diagnostic levels. Again, Education and Problem Identification/Referral are a large part of providing service to this audience successfully.

Figure 7

Institute of Medicine Population Categories by Federal Strategy Prevention Services as Reported to PBPS in 2011-2012

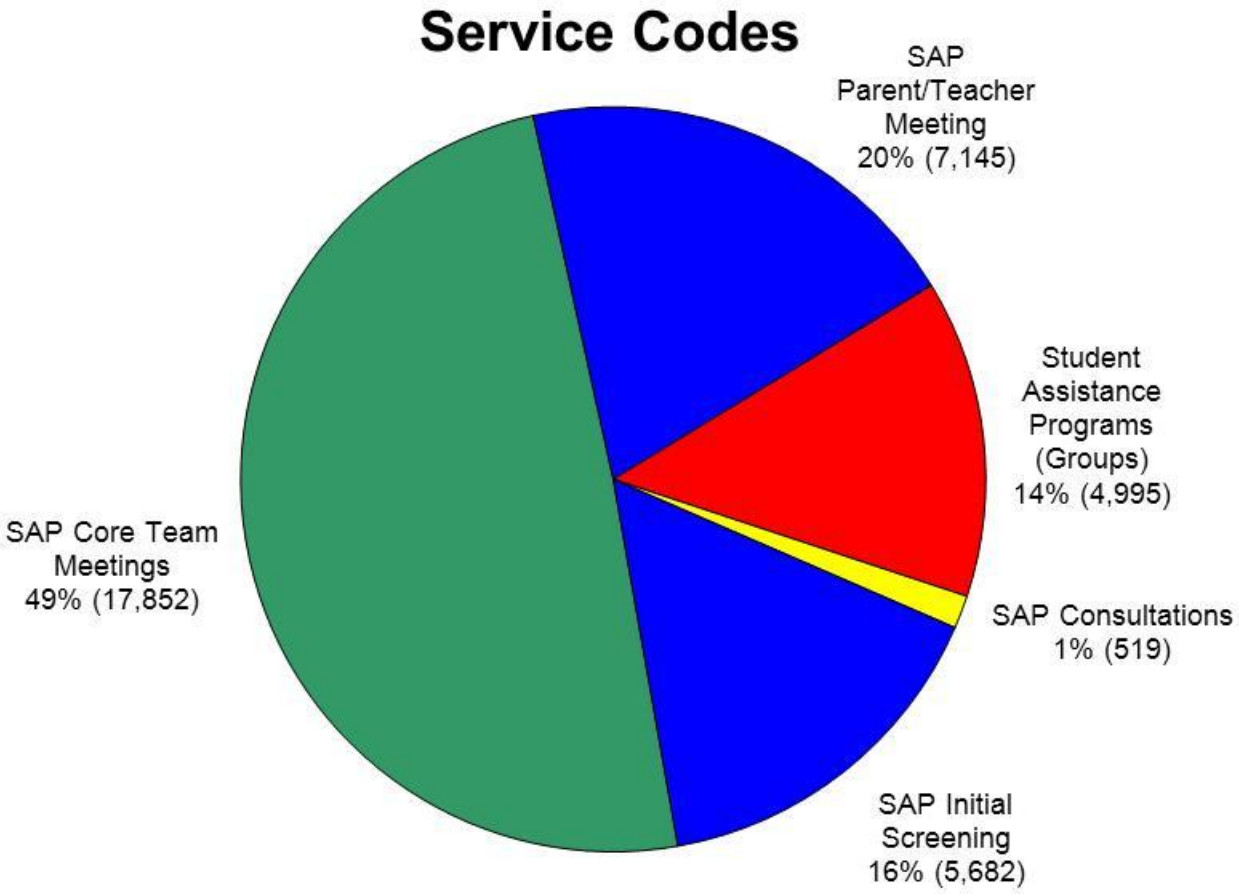


Student Assistance Data

The Student Assistance Program (SAP) is an important intervention for the youth in Pennsylvania. Figure 8 shows a total of 36,193 SAP services for Fiscal Year 2011-2012 broken down into their specific approach (service code). The SAP referrals were initiated by teachers, parents or counselors. These educational services are provided to SAP-identified students only. SAP assists school personnel in identifying issues like alcohol, tobacco and other drugs, as well as mental health issues which can impede students' success. Services include assessment, consultation, referral and/or small group education for SAP-identified youth. SAP is mandated to all SCAs to complement their prevention initiatives.

Figure 8

Student Assistance Programs (SAP) as Reported to PBPS SFY 2011-2012



Total SAP Services: 36,193

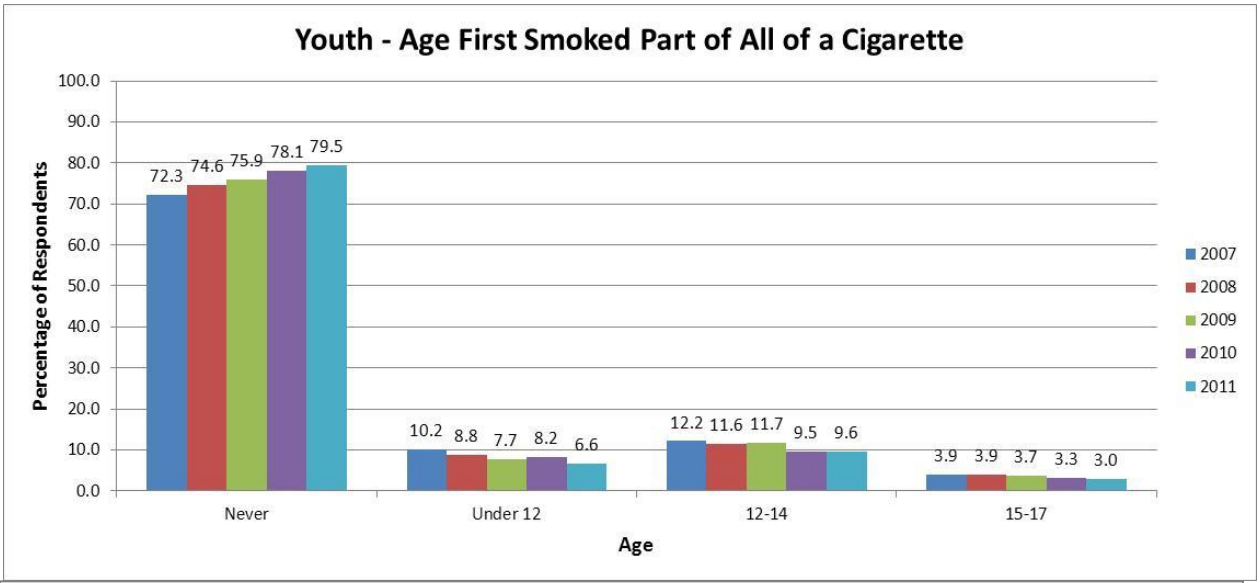
Youth National Outcome Measures (NOMs) Survey Results as Reported to the Performance Based Prevention System (PBPS)

The following surveys were gathered from Pennsylvania youth who attended selected single prevention services and recurring prevention services from October 1st to November 30th of 2007 (n=12,096), 2008 (n=10,993), 2009 (n=11,226), 2010 (n=14,312), and 2011 (n=12,635). The October to November timeframe helps provide some consistency to these survey results from year to year. Because service participants or attendees are not necessarily representative of the general population, please consider this a convenience sample.

Demographic Breakdown of 2011 Respondents	
Sex	
Male	48.93%
Female	51.07%
Age	
Under 12	14.75%
12-14	61.23%
15-17	22.24%
18-21	01.78%
Race	
White	77.93%
Black	10.27%
Other*	07.42%
Unknown	04.38%
Ethnicity	
Hispanic or Latino	09.64%
Not Hispanic or Latino	90.36%

** Category of Other includes the following: American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, and More than One Race*

Question 01T: How old were you the first time you smoked part or all of a cigarette?

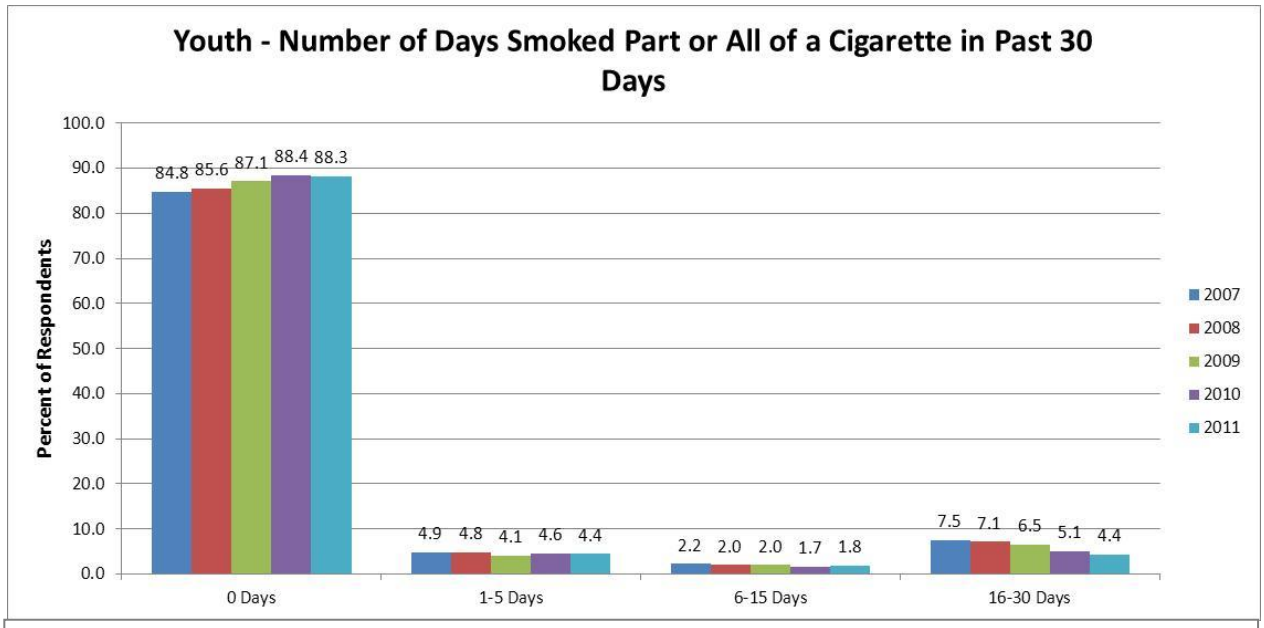


* The graph above shows only three of the categories of responses to the question. The table below shows the % of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in schools and some high school students may be age 18, this survey has captured data from some respondents who were 18 years old. The small %ages for the 18-21 category in the table below are due in large part to the very small number of respondents who were 18 or older and therefore, able to respond that they had their first drink at that age.

	2007	2008	2009	2010	2011
18-21	0.36%	0.38%	0.34%	0.36%	0.16%
No Response	1.08%	0.81%	0.57%	0.52%	1.11%

Age at first use of cigarettes among youth respondents has shown positive trends over the past five years. The percentage reporting no lifetime use has increased every year from 2007-2011 with an overall increase of 7.2% from 2007 to 2011.

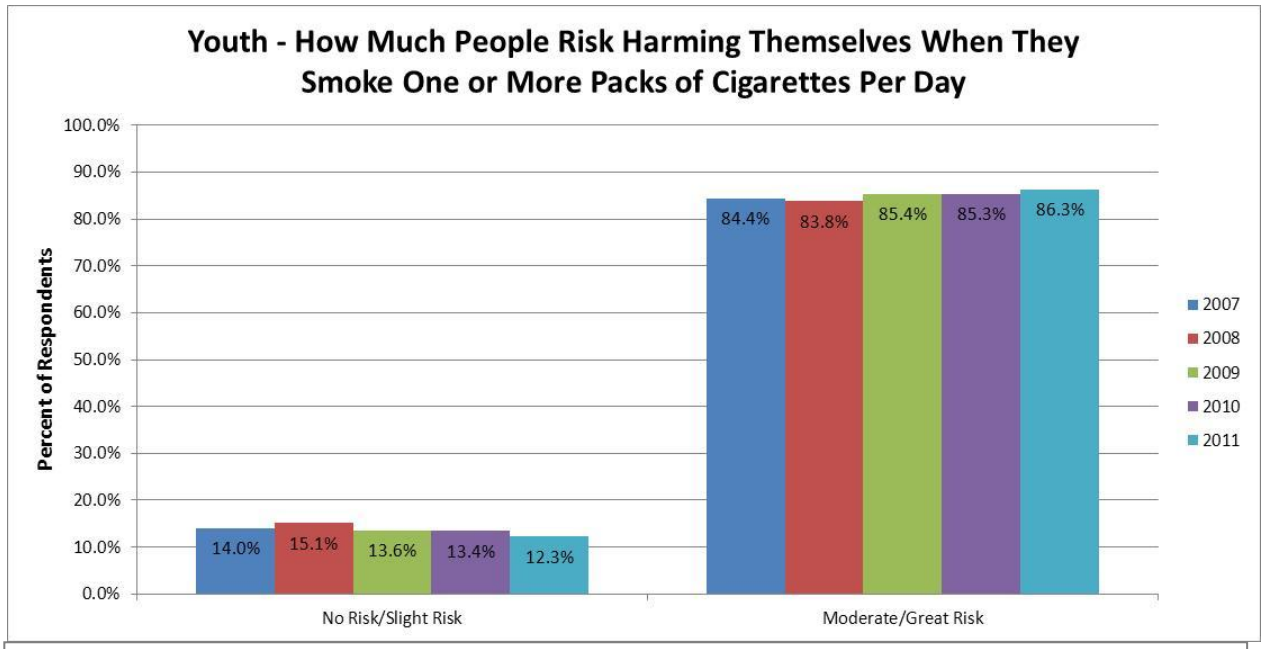
Question 02T: During the past 30 days, on how many days did you smoke part or all of a cigarette?



* .61% (2007), .52% (2008), .34% (2009), .25% (2010) and 1.09% (2011) of survey respondents did not respond to this question.

Past 30 day cigarette use among youth respondents has shown positive trends over the five years depicted above. The percentage reporting no past 30 day use has increased every year from 2007-2010 and remained the same in 2011. This reduction has been accompanied by a 3.1% decrease from 2007 to 2011 in the number of respondents reporting cigarette use on 16-30 days out of the past 30 days. Declines in past 30 day cigarette use were also reported on the 2010 National Survey on Drug Use and Health for youth aged 12-17 for every year from 2002-2010.

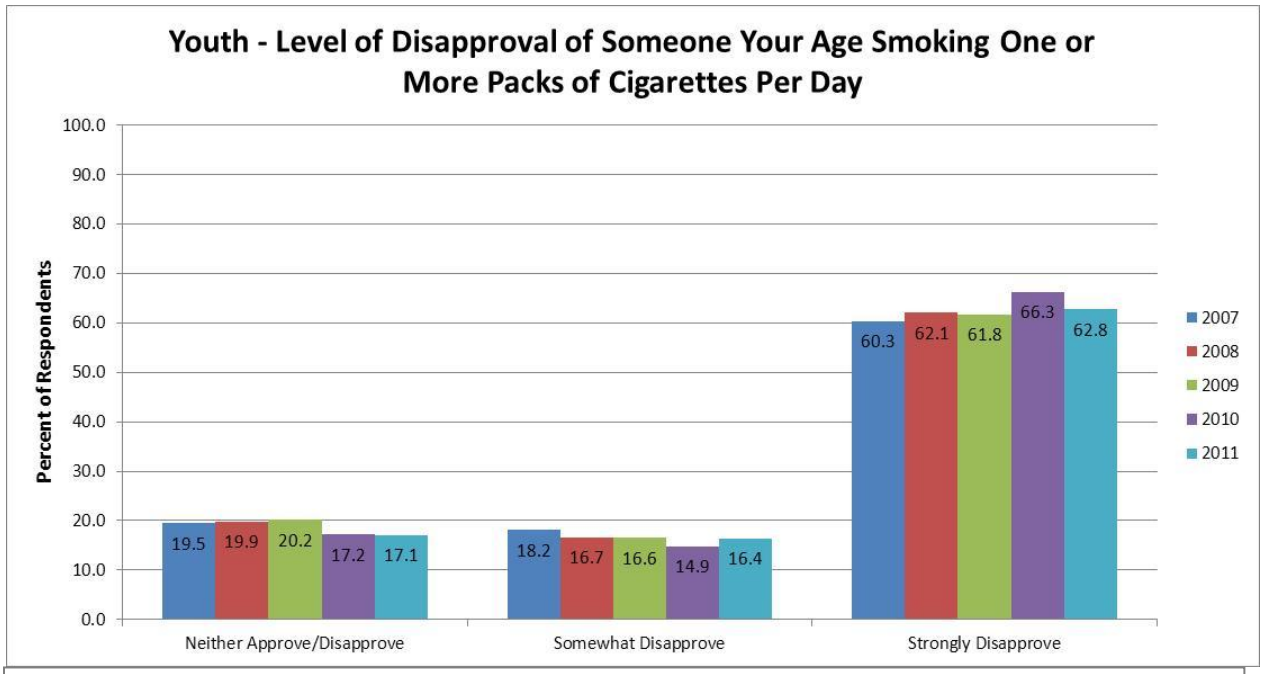
Question 03T: How much do people risk harming themselves physically and in other ways when they smoke one or more pack of cigarettes per day?



* 1.59% (2007), 1.07% (2008), 1.02% (2009), 1.17% (2010) and 1.39% (2011) of survey respondents did not respond to this question.

The percentage of youth respondents reporting that smoking one or more pack of cigarettes per day poses a moderate or great risk of harm has remained nearly the same every year from 2007-2011, but shows a very slight upward trend. Each year more respondents reported that smoking one or two packs of cigarettes per day posed a moderate or great risk of harm than reported that smoking marijuana and drinking alcohol posed a moderate or great risk of harm. In 2011 65.9% of respondents reported great risk which is close to the 65.5% reported on the 2010 National Survey on Drug Use and Health for youth aged 12-17.

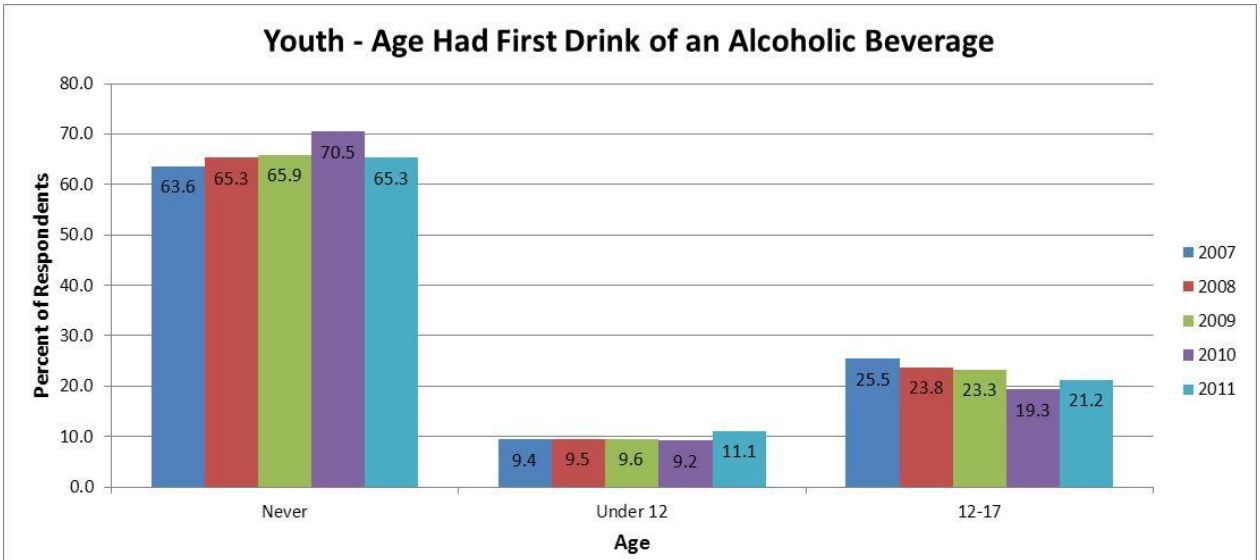
Question 04T: How do you feel about someone your age smoking one or more packs of cigarettes a day?



* 2.06% (2007), 1.35% (2008), 1.43% (2009), 1.59% (2010) and 3.74% (2011) of survey respondents did not respond to this question.

The percentage of youth respondents who reported that they strongly disapproved of someone their age smoking one or more packs of cigarettes per day decreased from 2010 to 2011, but was still higher in 2011 than in 2007-2009. The percentage of youth reporting they neither approved or disapproved was lower in 2011 than the four previous years.

Question 01A: How old were you the first time you had a drink of an alcoholic beverage?

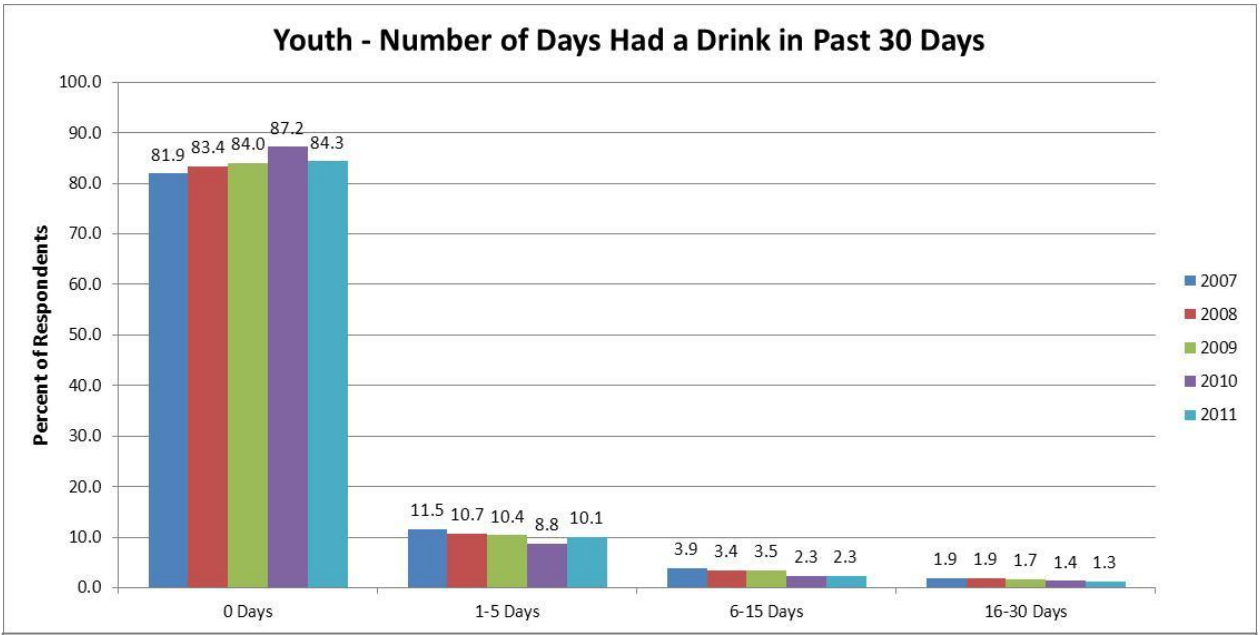


* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in schools and some high school students may be age 18, this survey has captured data from some respondents who were 18 years old. The small percentages for the 18-21 category in the table below are due in large part to the very small number of respondents who were 18 or older and therefore able to respond that they had their first drink at that age.

	2007	2008	2009	2010	2011
18-21	0.36%	0.55%	0.45%	0.36%	0.28%
No Response	1.16%	0.86%	0.82%	0.64%	2.06%

The percentage of youth respondents reporting they never drank alcohol remained at 65% in 2008 and 2009, increased by almost 5% in 2010, and then decreased back to 65% in 2011. Alcohol is the substance that was most commonly reported to have ever been used by youth respondents.

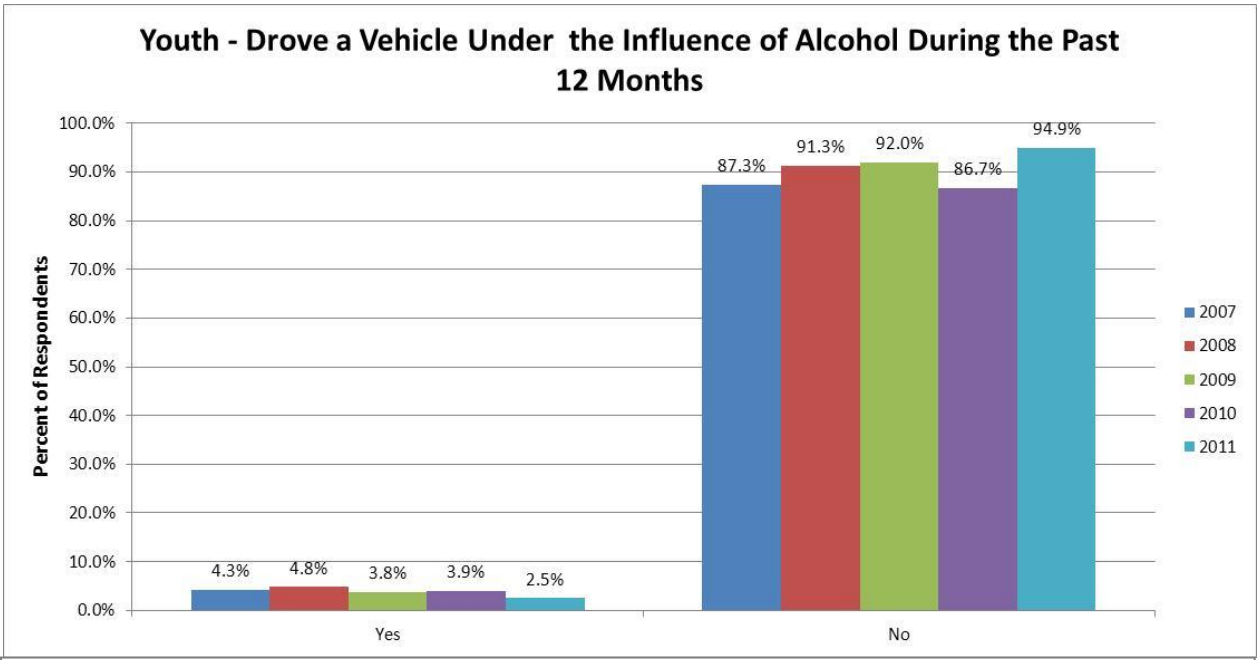
Question 02A: During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?



* .74% (2007), .69% (2008), .45% (2009), .38% (2010) and 1.97% (2011) of survey respondents did not respond to this question.

The percentage of youth reporting no use of alcohol in the past 30 days decreased from 2010 to 2011, but was still slightly higher in 2011 than in 2007-2009. Alcohol is the substance that was most commonly reported to have been used in the past 30 days by youth respondents. In 2011 13.7% of respondents reported past 30 day use which is similar to the national percentage of 13.6% reported on the 2010 National Survey on Drug Use and Health for youth aged 12-17.

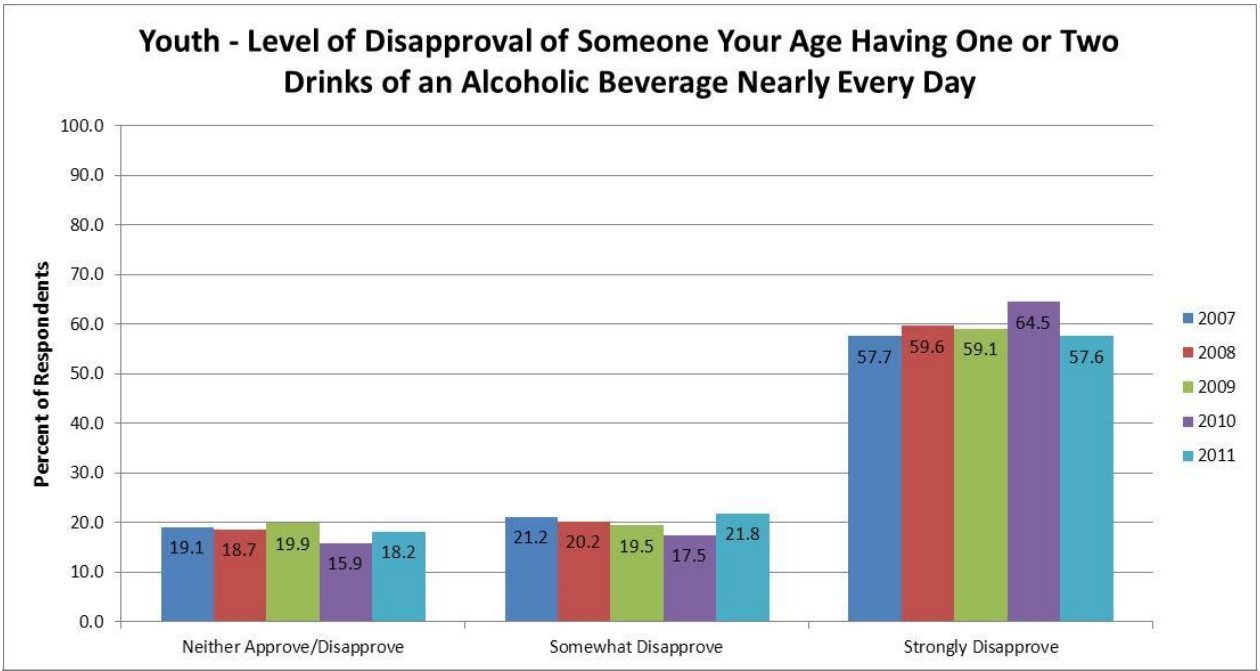
Question 03A: During the past 12 months, have you driven a vehicle while you were under the influence of alcohol only?



* 8.37% (2007), 3.95% (2008), 4.21% (2009), 9.32% (2010) and 2.60% (2011) of survey respondents did not respond to this question.

The percentage of youth reporting that they drove under the influence has stayed relatively low at approximately 4% from 2007-2010 and dropped even lower in 2011 to 2.5%. In 2011 looking at only those respondents that were 16 or older (n=1948), 5.7% reported that they drove under the influence in the past 12 months.

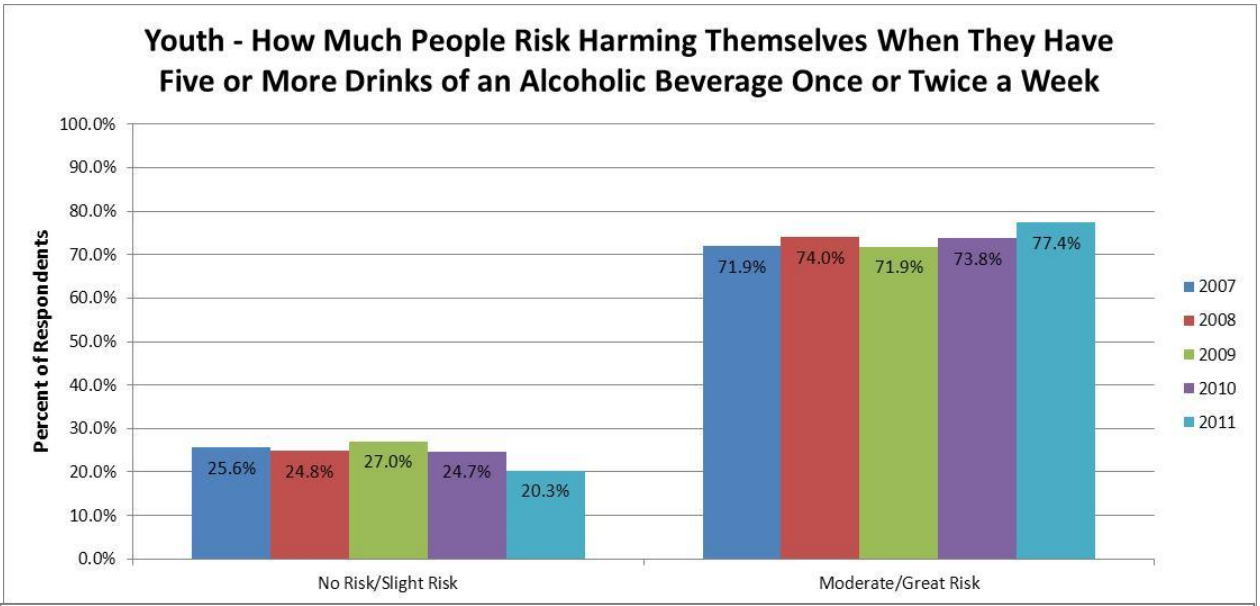
Question 04A: How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?



* 2.03% (2007), 1.48% (2008), 1.47% (2009), 1.94% (2010) and 2.34% (2011) of survey respondents did not respond to this question.

The percentage of youth respondents who reported that they strongly disapproved of someone their age having one or two drinks of an alcoholic beverage nearly every day decreased to the lowest point in the past 5 years. This decrease in strong disapproval was accompanied by an increase in those reporting that they somewhat disapproved.

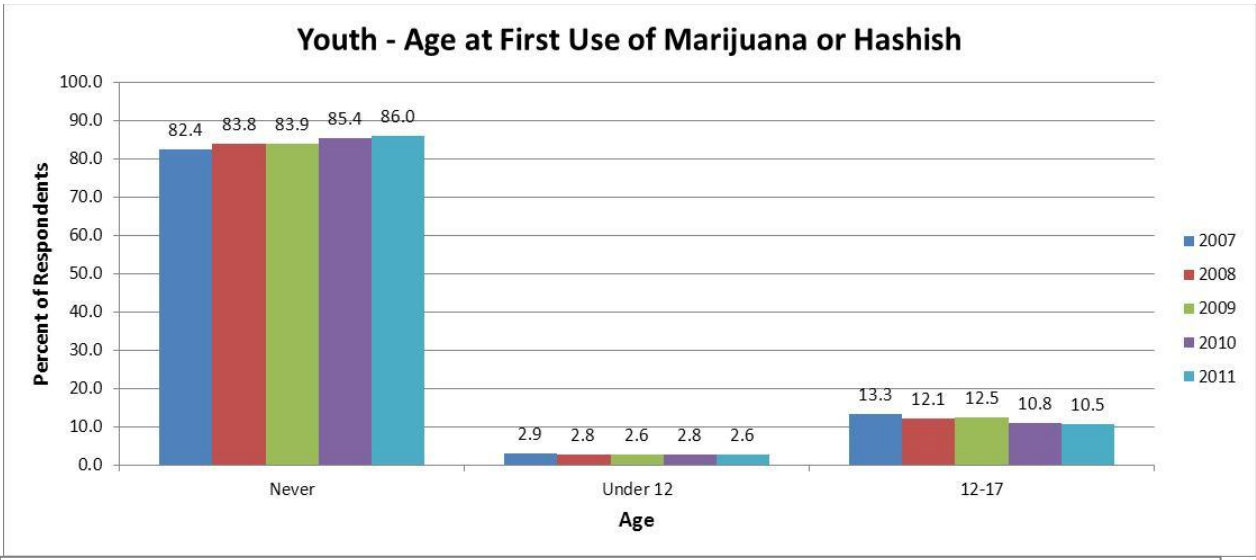
Question 05A: How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?



* 2.53% (2007), 1.26% (2008), 1.14% (2009), 1.47% (2010) and 2.23% (2011) of survey respondents did not respond to this question.

The percentage of youth respondents reporting that having five or more drinks of an alcoholic beverage once or twice a week poses a moderate or great risk of harm has fluctuated slightly each year, but shows an overall positive trend from 72% in 2007 up to 77% in 2011. Of the questions on the survey regarding the potential harm posed by use of certain substances, this question on alcohol use had the highest percentage of respondents reporting no or only slight risk for 2007-2010 (in 2011 it was second highest after marijuana). In 2010 and 2011 43% and 44.7% of respondents, respectively, reported great risk. This is close to the national percentage of 41% reported on the 2010 National Survey on Drug Use and Health for youth aged 12-17.

Question 01M: How old were you the first time you used marijuana or hashish?

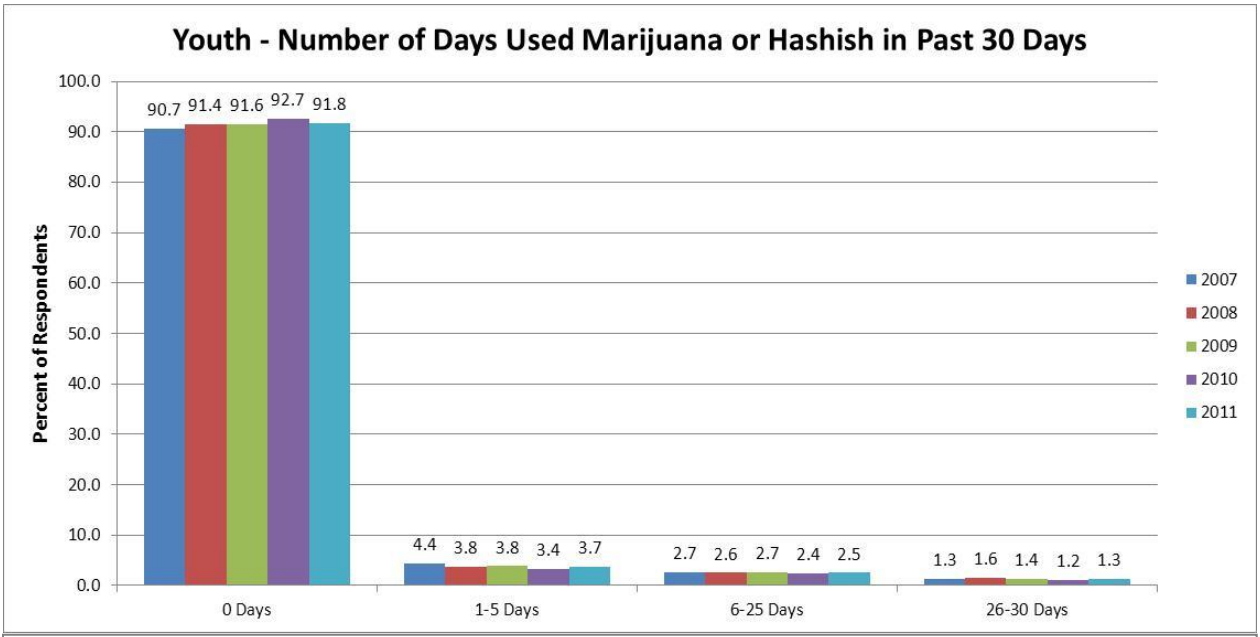


* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in schools and some high school students may be age 18, this survey has captured data from some respondents who were 18 years old. The small percentages for the 18-21 category in the table below are due in large part to the very small number of respondents who were 18 or older and therefore able to respond that they had first used marijuana at that age.

	2007	2008	2009	2010	2011
18-21	0.22%	0.45%	0.29%	0.31%	0.17%

The percentage of youth reporting that they have never used marijuana or hashish has increased slightly each year from 2007-2011. Looking across the past five years 13% (2011) to 16% (2007) of youth respondents reported using marijuana or hashish at least once in their lifetime.

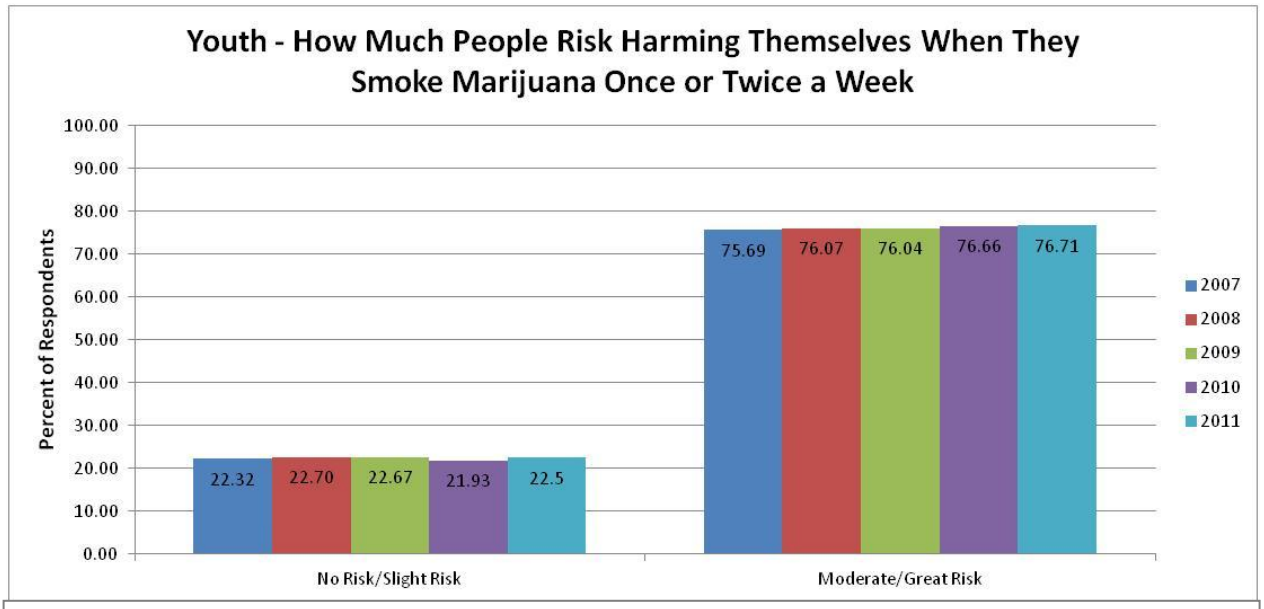
Question 02M: During the past 30 days, on how many days did you use marijuana or hashish?



* .81% (2007), .73% (2008), .52% (2009), .41% (2010) and .68% (2011) of survey respondents did not respond to this question.

From 2007 to 2010 there was a slight increase (2%) in the percentage of youth respondents reporting no use of marijuana or hashish in the past 30 days. The percentage of youth reporting no past 30 day use decreased by 1% in 2011. In 2010 the percentage of youth reporting past 30 day marijuana use had decreased to 7% (increased only slightly in 2011). This trend is in contrast to the national trend reported on the 2010 National Survey on Drug Use and Health which reports that past 30 day marijuana use among youth aged 12-17 increased from 6.7% in 2008 to 7.4% in 2010.

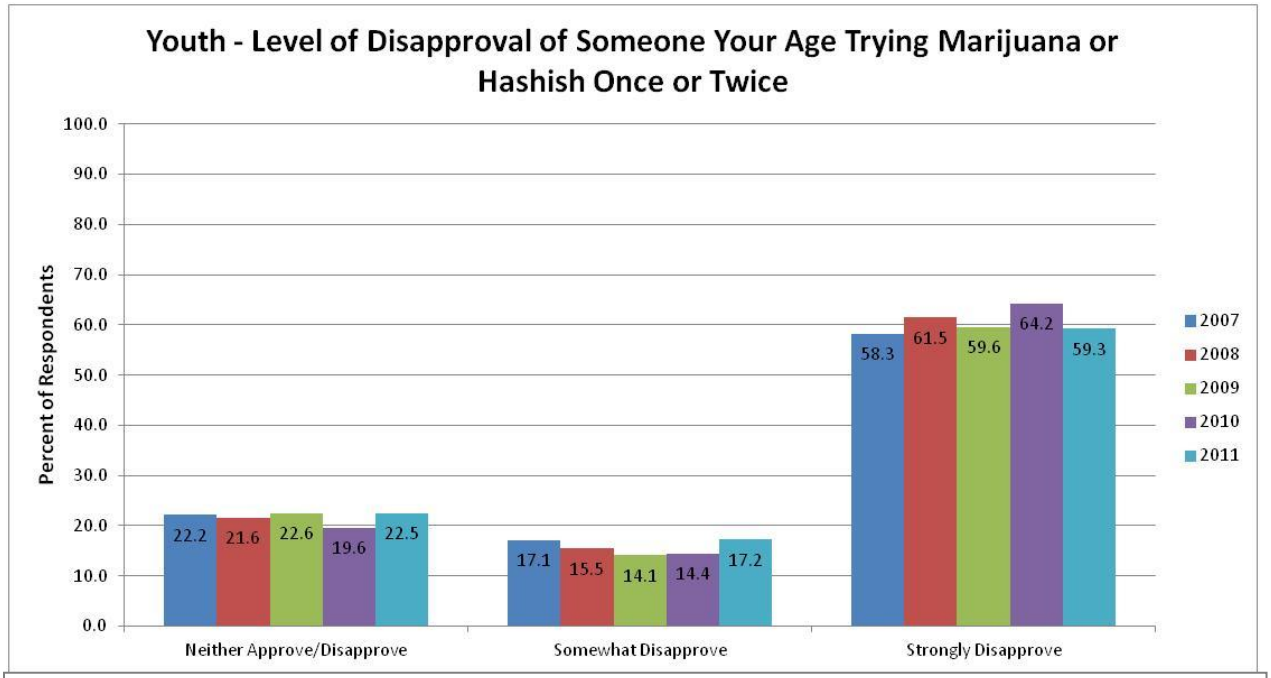
Question 03M: How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?



* 1.98% (2007), 1.24% (2008), 1.25% (2009), 1.34% (2010) and .79% (2011) of survey respondents did not respond to this question.

The percentage of youth respondents reporting that smoking marijuana once or twice a week poses a moderate or great risk of harm has remained nearly the same every year from 2007-2011. A high percentage (approximately 22% each year) reported no or slight risk from smoking marijuana once or twice a week. In 2010 and 2011 51% and 54% of respondents, respectively, reported great risk which is slightly higher than the national percentage of 47.5% reported on the 2010 National Survey on Drug Use and Health for youth aged 12-17.

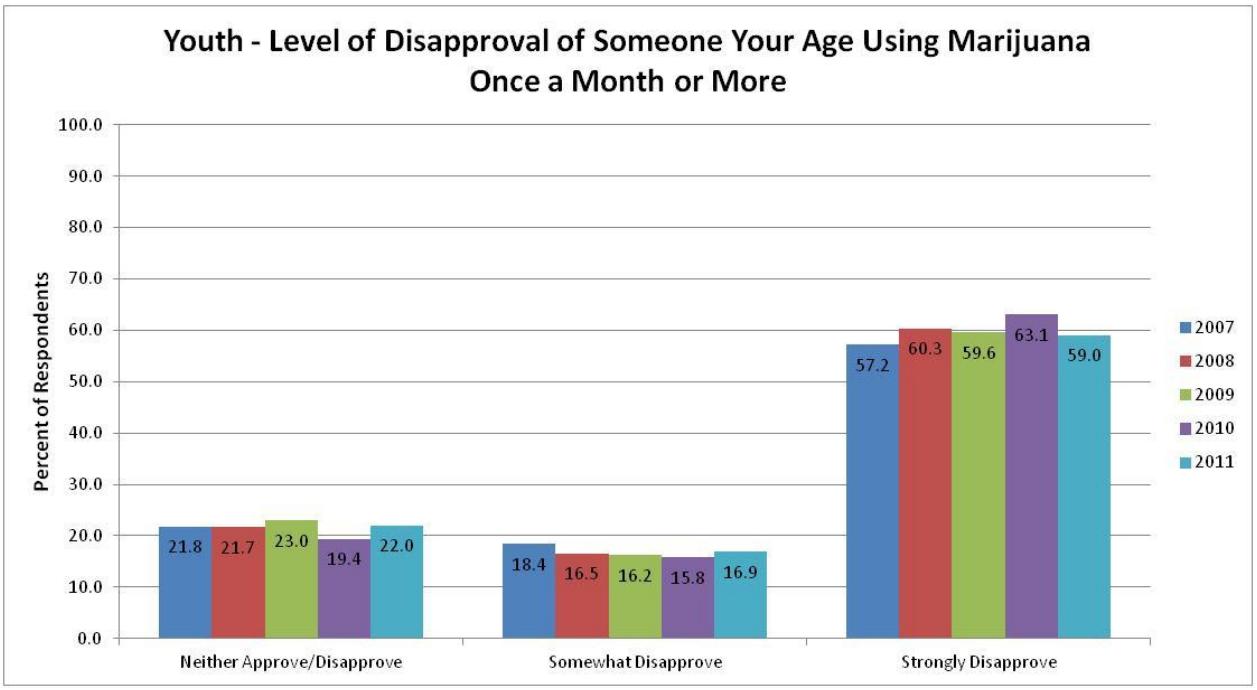
Question 04M: How do you feel about someone your age trying marijuana or hashish once or twice?



* 2.37% (2007), 1.48% (2008), 3.72% (2009), 1.72% (2010) and 1.07% (2011) of survey respondents did not respond to this question.

The percentage of youth respondents who reported that they strongly disapproved of someone their age trying marijuana or hashish once or twice has fluctuated each year with a low of 58.3% in 2007 and a high of 64.2% in 2010.

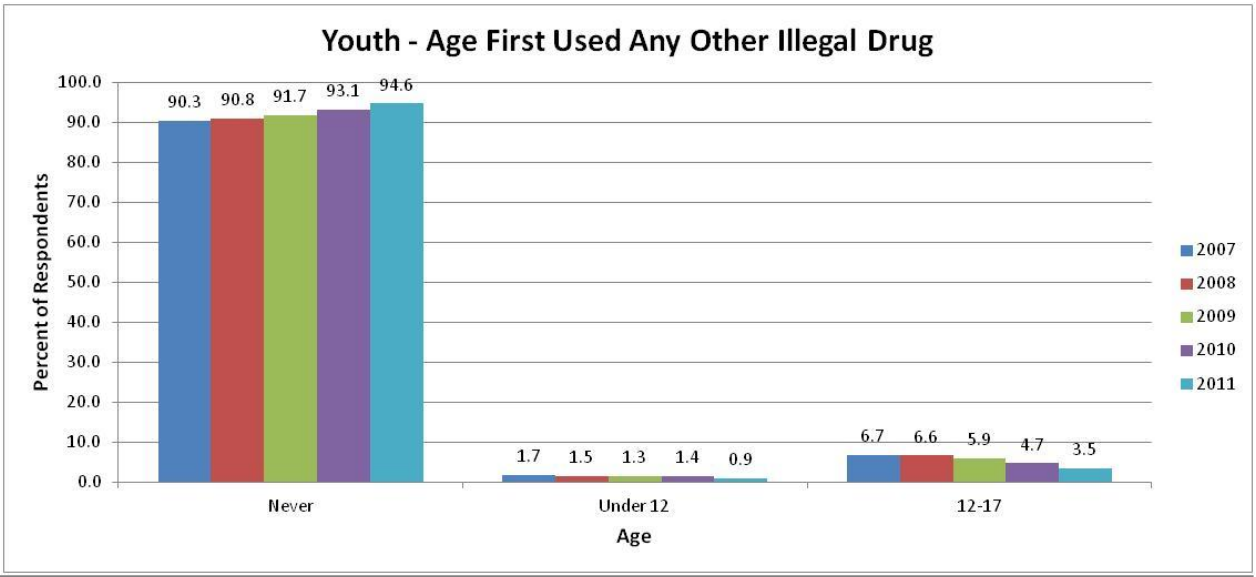
Question 05M: How do you feel about someone your age using marijuana once a month or more?



* 2.53% (2007), 1.49% (2008), 1.31% (2009), 1.65% (2010) and 2.11% (2011) of survey respondents did not respond to this question.

The percentage of youth respondents who reported that they strongly disapproved of someone their age using marijuana once a month or more has increased by 6% between 2007 to 2010, but decreased in 2011. When comparing this table to the previous table on disapproval of trying marijuana once or twice the percentages in all categories for all years are very similar. This may indicate that respondents' disapproval of use was not related to how frequent the use was.

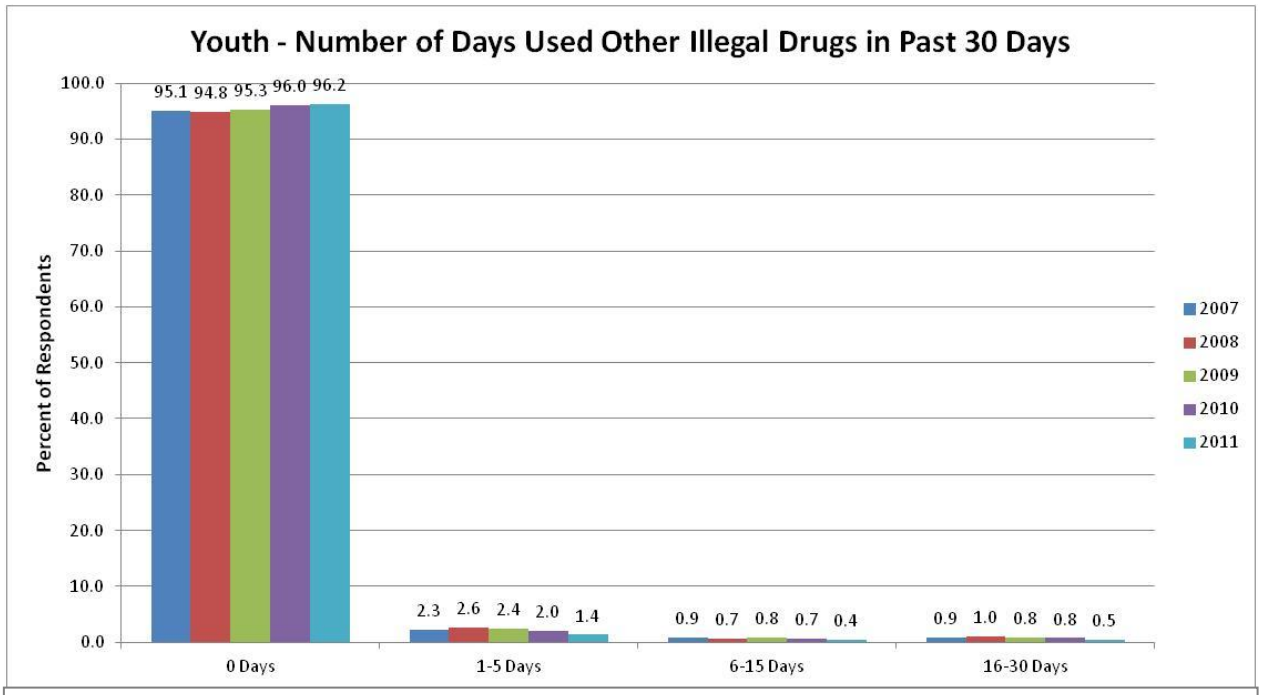
Question 01O: How old were you the first time you used any other illegal drug? Other illegal drugs include substances such as: Heroin, crack or cocaine, methamphetamine, Hallucinogens (such as LSD, Ecstasy, PCP or peyote).



* The graph above shows only three of the categories of responses to the question. The table below shows the percent of respondents who selected 18-21 and who did not respond. Note that the Youth NOMs Survey is designed to survey individuals under age 18. Since the NOMs survey is often administered in schools and some high school students may be age 18, this survey has captured data from some respondents who were 18 years old. The small percentages for the 18-21 category in the table below are due in large part to the very small number of respondents who were 18 or older and therefore able to respond that they had first used drugs at that age.

	2007	2008	2009	2010	2011
18-21	0.17%	0.30%	0.34%	0.22%	0.17%
No Response	1.17%	0.80%	0.70%	0.61%	0.88%

Question 02O: During the past 30 days, on how many days did you use any other illegal drug? Other illegal drugs include substances such as: Heroin, crack or cocaine, methamphetamine, Hallucinogens (such as LSD, Ecstasy, PCP or peyote).



* .93% (2007), .99% (2008), .58% (2009), .49% (2010) and 1.53% (2011) of survey respondents did not respond to this question.

The percentage of youth reporting no use of other illegal drugs during the past 30 days has stayed consistently high at about 95%. The 2010 National Survey on Drug Use and Health reports that 10.1% of youth aged 12-17 used illicit drugs (includes marijuana) during the past 30 days.

Question 01P: Have you ever taken prescription medications that were not prescribed specifically for you?
This question was added to the youth NOMs survey in 2011. 14% answered yes, 83.40% answered no and 2.60% did not answer.

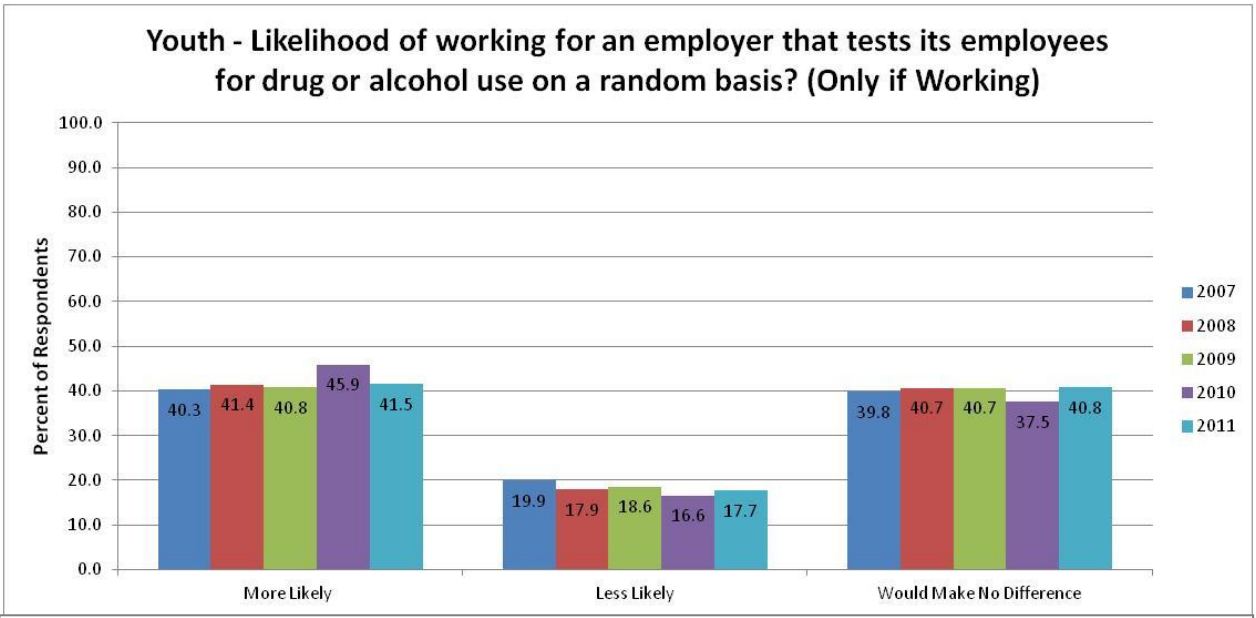
Question 02P: How much do people risk harming themselves physically and in other ways when they take prescription medications not specifically prescribed for them?
This question was added to the youth NOMs survey in 2011. 18.13% answered no or slight risk, 78.97% answered moderate or great risk, and 2.90% did not answer.

Question 01I: How much do people risk harming themselves physically and in other ways using inhalants or sniffing substances?
This question was added to the youth NOMs survey in 2011. 16.13% answered no or slight risk, 81.18% answered moderate or great risk, and 2.68% did not answer.

Question 02I: Have you ever snorted, sniffed, or huffed on a substance for the purpose of experiencing a high?
This question was added to the youth NOMs survey in 2011. 8.1% answered yes, 88.36% answered no and 3.55% did not answer. The percentage of youth reporting lifetime use of inhalants is almost the same as the national percentage of 8.2% reported on the 2010 National Survey on Drug Use and Health for youth aged 12-17.

Question 01S: How much do people risk harming themselves physically and in other ways using synthetic drugs?
This question was added to the youth NOMs survey in 2011. 13.87% answered no or slight risk, 83.55% answered moderate or great risk, and 2.59% did not answer.

Question 01Z: Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis?

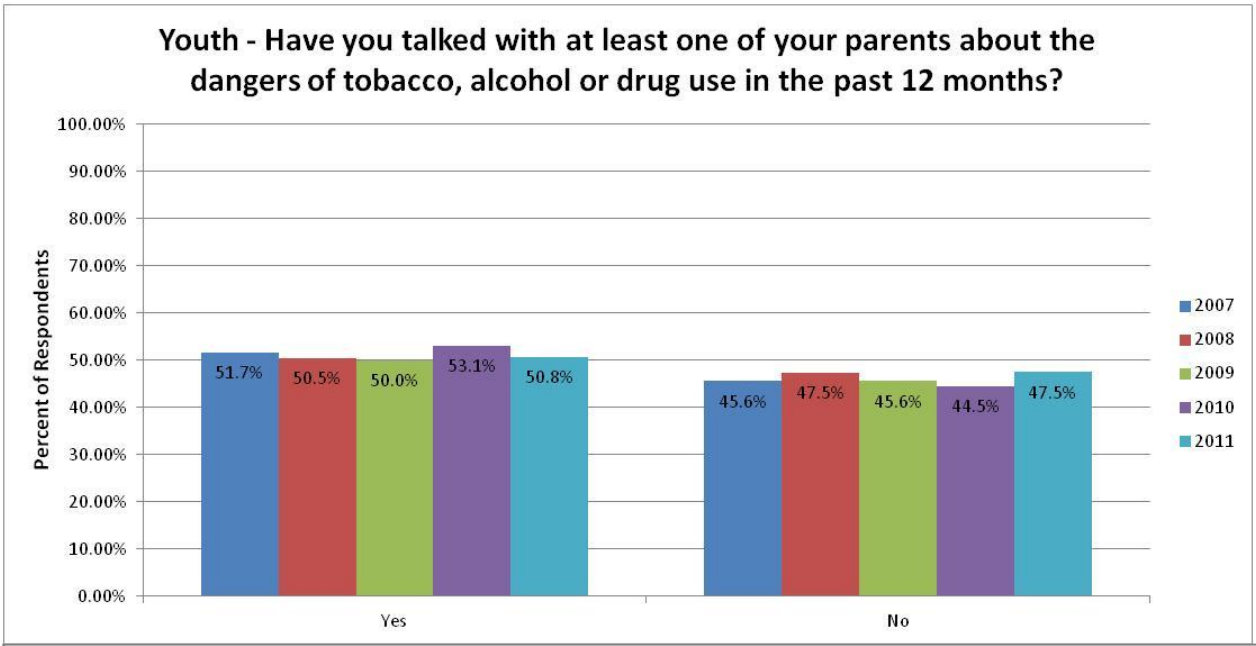


* The percentages in the graph above were calculated out of the total number of respondents who chose one of the three answer choices shown (n=7293 for 2007, n=7135 for 2008, n=6965 for 2009, n=9325 for 2010, n=7575 for 2011). Those who selected not applicable or did not answer this question were not included in the denominator when calculating the percentages. The percent who selected Not Applicable or who did not respond, calculated out of the total number of respondents, is shown in the table below.

	2007	2008	2009	2010	2011
Not Applicable	31.83%	27.88%	30.38%	24.94%	35.41%
No Response	7.88%	7.23%	7.56%	9.83%	4.64%

The percentage of youth reporting that they would be more likely to work for an employer that randomly tests it employees for drug and alcohol use remained nearly the same from 2007-2009 (approximately 41%), increased about 5% in 2010, and the returned to 41% in 2011.

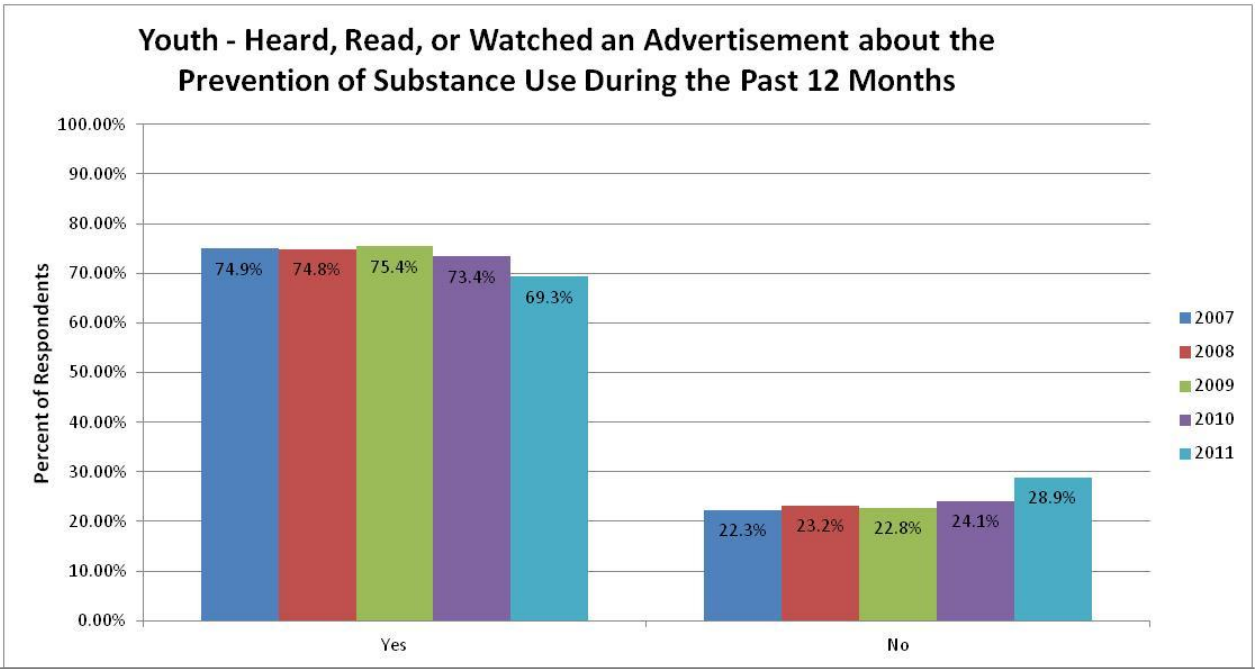
Question 02Z: During the past 12 months, have you talked to your parents about the dangers of tobacco, alcohol or drug use?



* 2.70% (2007), 2.02% (2008), 4.37% (2009), 2.20% (2010) and 1.72% (2011) of survey respondents did not respond to this question.

The percentage of youth reporting they have talked with their parents about the dangers of tobacco, alcohol, or drug use has remained at approximately 50% over the past 5 years.

Question 03Z: During the past 12 months, do you recall hearing, reading, or watching an advertisement about the prevention of substance use?



* 2.74% (2007), 2.00% (2008), 1.84% (2009), 2.31% (2010) and 1.84% (2011) of survey respondents did not respond to this question.

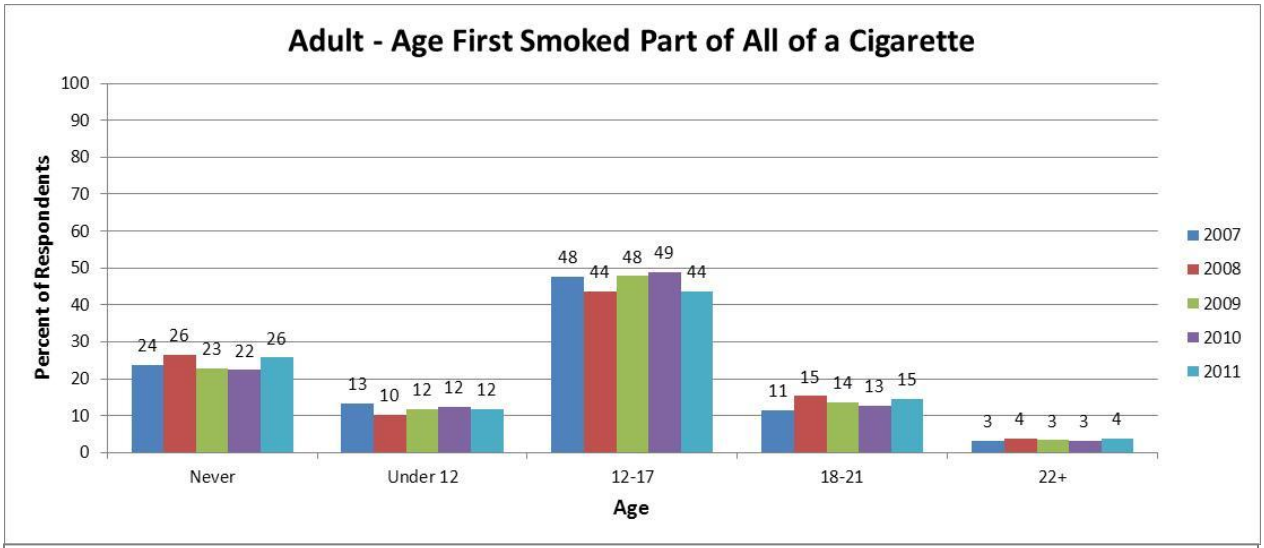
The percentage of youth reporting hearing, reading, or watching an advertisement about the prevention of substance use stayed nearly the same from 2007-2009 (approximately 75%), but decreased in 2010 and 2011. Between 2007 and 2011 the % of youth reporting that they had not heard, read, or watched a substance abuse prevention advertisement in the past year increased by over 6%.

Adult National Outcome Measures (NOMs) Survey Results as Reported to the Performance Based Prevention System (PBPS)

The following surveys were gathered from Pennsylvania adults who attended selected single prevention services and recurring prevention services from October 1st to November 30th of 2007 (n=3145), 2008 (n=3558), 2009 (n=4765), 2010 (n=5537) and 2011 (n=4989). The October to November timeframe helps provide some consistency to these survey results from year to year. Because service participants or attendees are not necessarily representative of the general population, please consider this a convenience sample.

Demographic Breakdown of 2011 Respondents	
Sex	
Male	37.08%
Female	62.92%
Age	
18-25	19.74%
26-40	36.92%
41-59	33.57%
60+	09.58%
Unknown	00.18%
Race	
White	78.35%
Black	14.57%
Other*	03.89%
Unknown	03.19%
Ethnicity	
Hispanic or Latino	04.93%
Not Hispanic or Latino	95.07%
** Category of Other includes the following: American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, and More than One Race*	

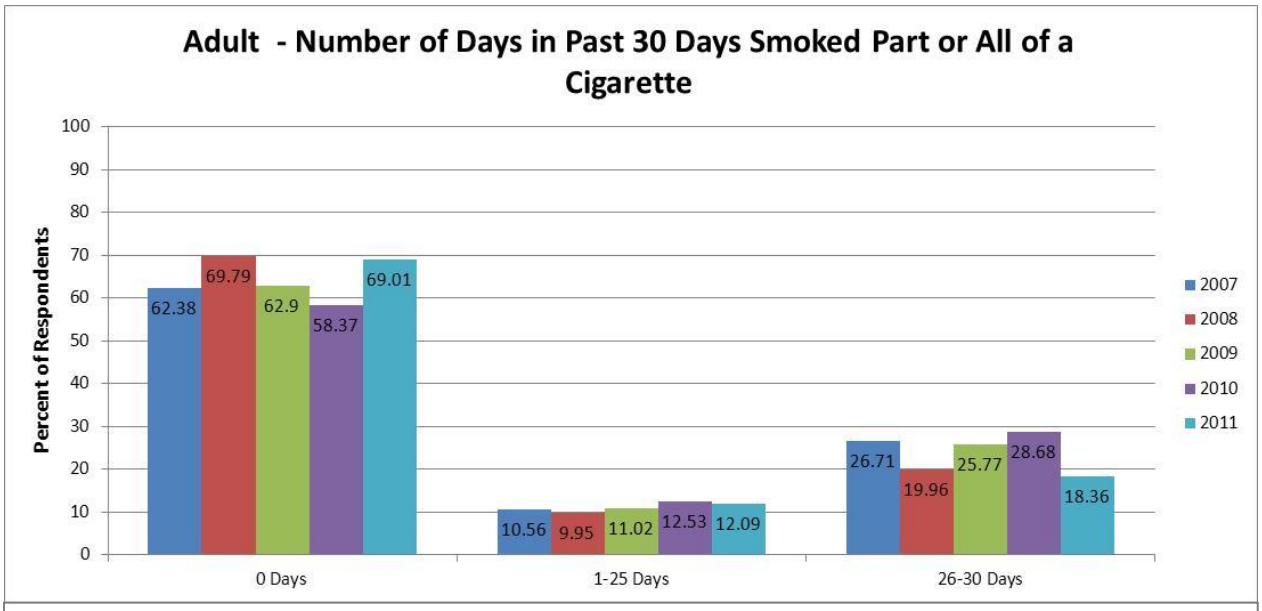
Question 01T: How old were you the first time you smoked part or all of a cigarette?



* .92% (2007), .56% (2008), .67% (2009), .69% (2010) and .46% (2011) of survey respondents did not respond to this question.

Each year just slightly less than half of the adult respondents reported that they first smoked a cigarette between the ages of 12 and 17. The percentage of adults reporting that they have never smoked has ranged from 22.3% in 2010 to 26.5% in 2010.

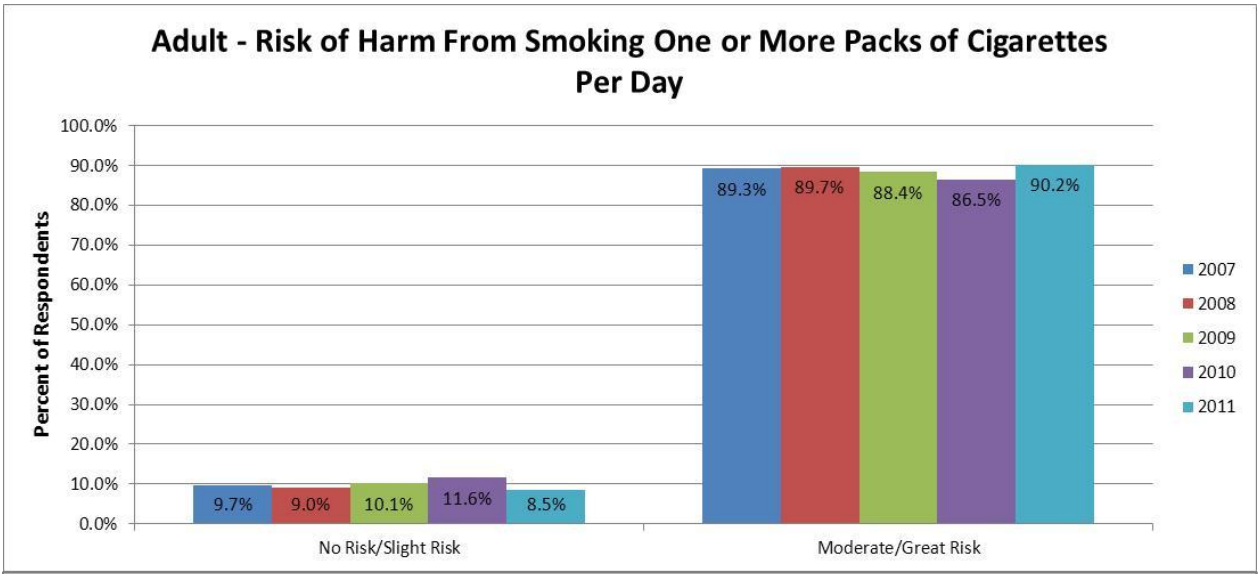
Question 02T: During the past 30 days, on how many days did you smoke part or all of a cigarette?



* .32% (2007), .34% (2008), .38% (2009), .49% (2010) and .54% (2011) of survey respondents did not respond to this question.

Past 30 day cigarette use among adult respondents has fluctuated over the past 5 years with a spike in 2011 of the percentage reporting no past 30 day use. The percentage reporting past 30 day cigarette use was lowest in 2008 and highest in 2010. In 2011 30.5% of adults reported past 30 day use of cigarettes.

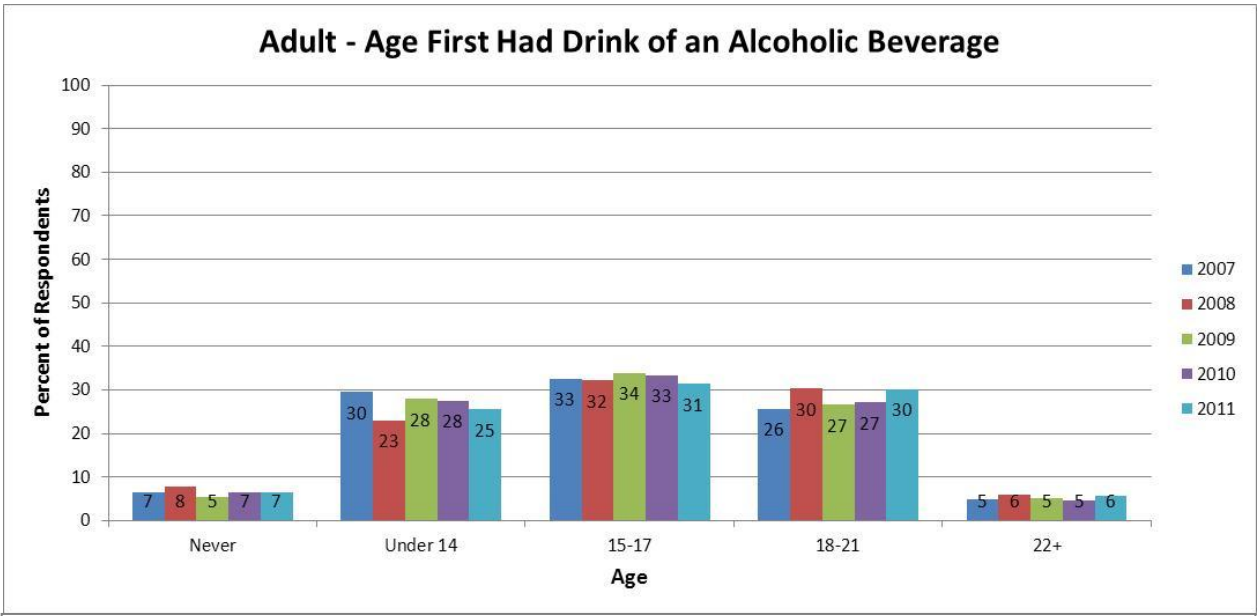
Question 03T: How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?



* 1.08% (2007), 1.29% (2008), 1.43% (2009), 1.82% (2010) and 1.22% (2011) of survey respondents did not respond to this question.

The number of adults reporting moderate or great risk of harm from smoking one or more packs of cigarettes per day was near 90% in 2007 and 2008, decreased slightly in 2009 and 2010 and went back up to 90% in 2011. Each year more adults reported that smoking one or two packs of cigarettes per day posed a moderate or great risk of harm than reported that smoking marijuana and drinking alcohol posed a moderate or great risk of harm.

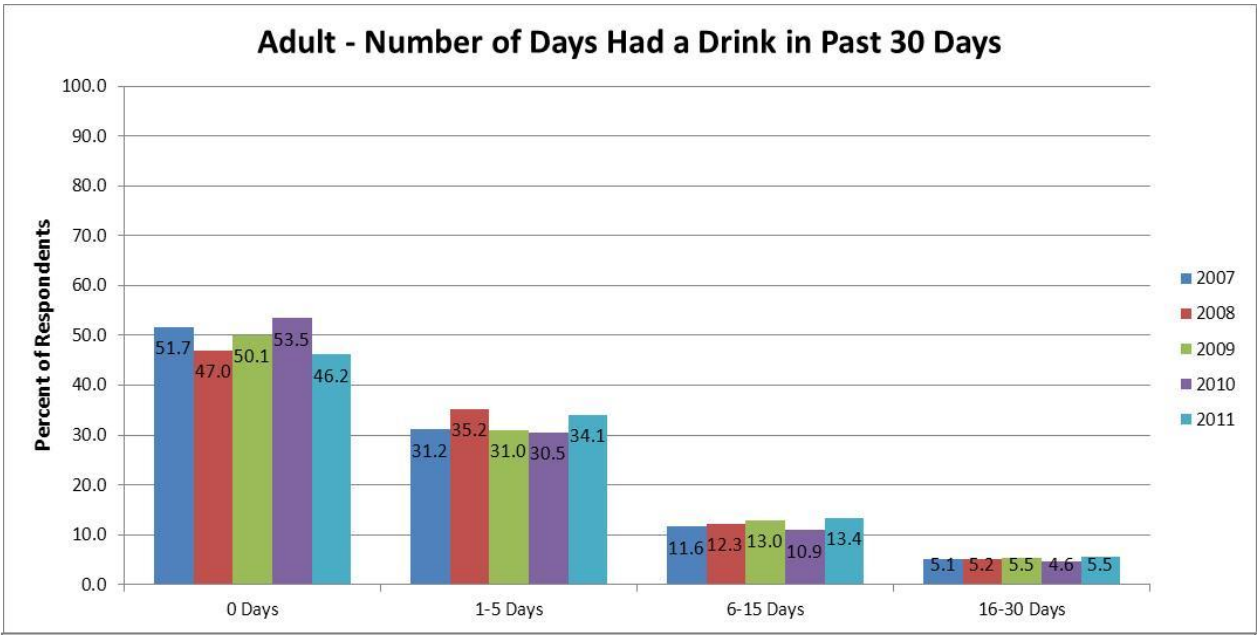
Question 01A: How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.



* .76% (2007), .79% (2008), 1.07% (2009), .88% (2010) and .74% (2011) of survey respondents did not respond to this question.

For each year from 2007-2010 about 33% of adult respondents reported that they had their first drink of an alcoholic beverage between the ages of 15 and 17. In 2011 this decreased slightly to 31%.

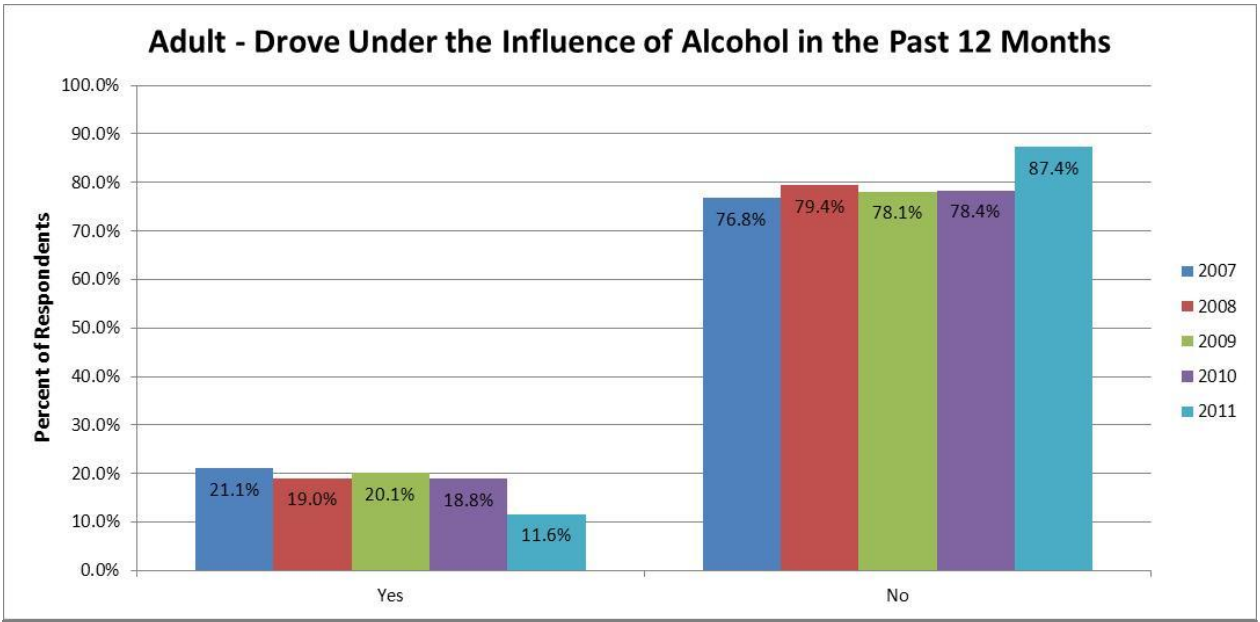
Question 02A: During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?



* .41% (2007), .39% (2008), .52% (2009), .43% (2010) and .72% (2011) of survey respondents did not respond to this question.

The percentage of adults reporting that they had a drink on 5 or less days out of the past 30 days has remained above 80% for 2007-2011 with a high of 84% in 2010 and a low of 80.3% in 2011.

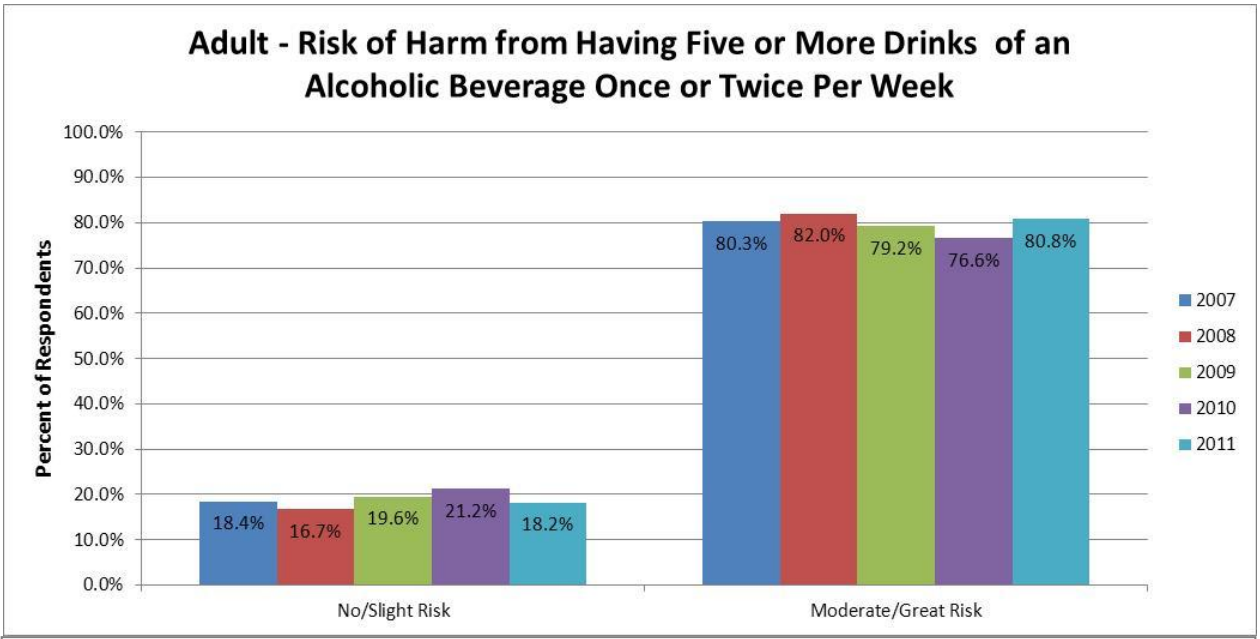
Question 03A: During the past 12 months, have you driven a vehicle while you were under the influence of alcohol only?



* 2.13% (2007), 1.63% (2008), 1.76% (2009), 2.65% (2010) and 1.08% (2011) of survey respondents did not respond to this question.

The percentage of adults reporting that they drove under the influence has fluctuated slightly each year, but shows an overall downward trend. In 2011 nearly 11.6% of respondents reported that they drove under the influence in the past 12 months.

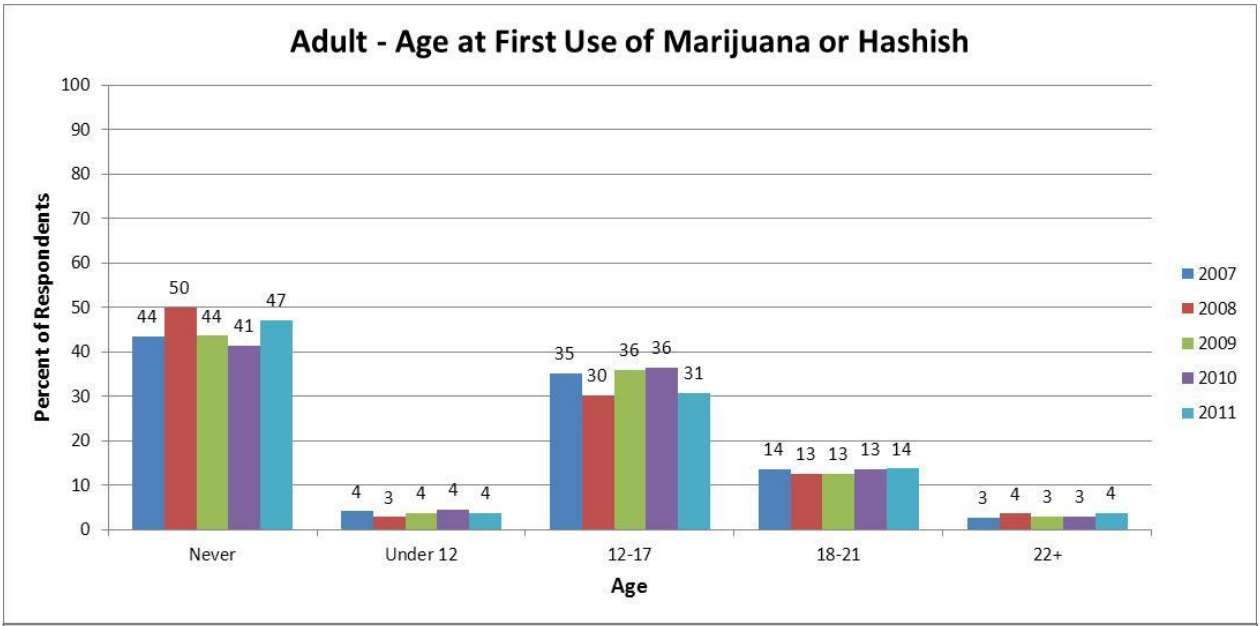
Question 04A: How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?



* 1.27% (2007), 1.29% (2008), 1.22% (2009), 2.20% (2010) and 1.00% (2011) of survey respondents did not respond to this question.

The percentage of adults reporting moderate/great risk from having five or more drinks of an alcoholic beverage once or twice per week decreased each year from 2008 through 2010 but increased by over 4% in 2011 to 80.8%.

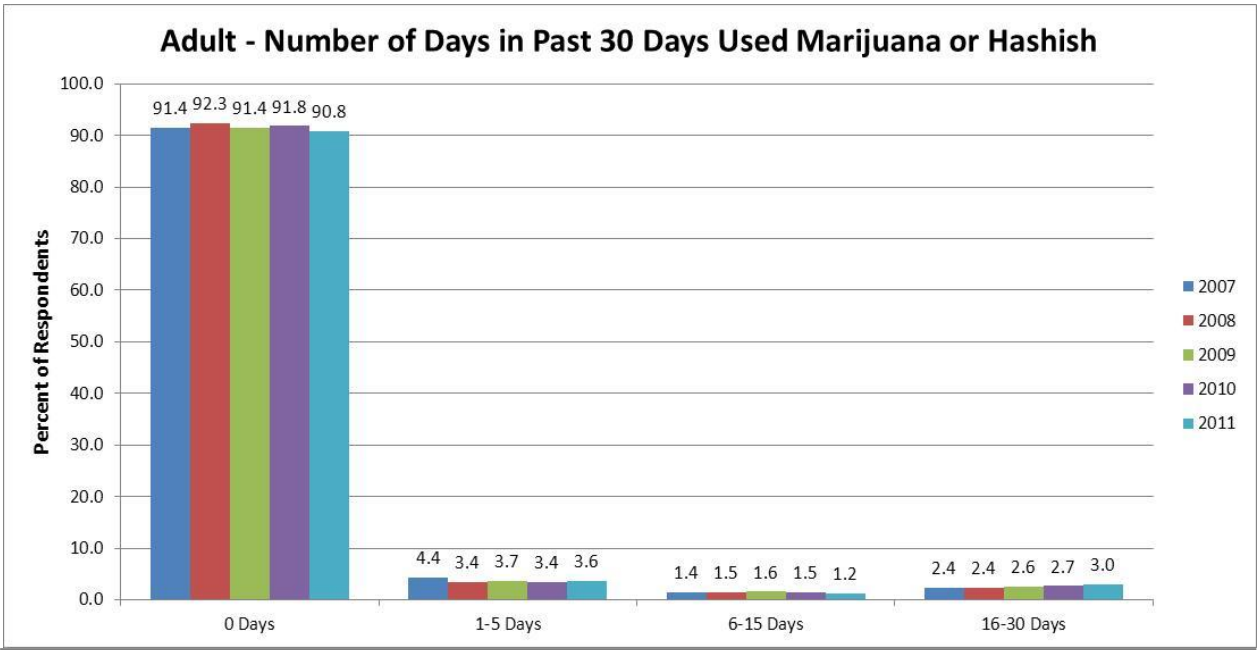
Question 01M: How old were you the first time you used marijuana or hashish?



* .99% (2007), .98% (2008), 1.39% (2009), 1.46% (2010) and 1.18% (2011) of survey respondents did not respond to this question.

The percentage of adults reporting that they have never used marijuana or hashish has fluctuated over the past 5 years. In 2011 approximately 53% of adult respondents reported that they had used marijuana or hashish. The most commonly reported age at first use was between 12 and 17.

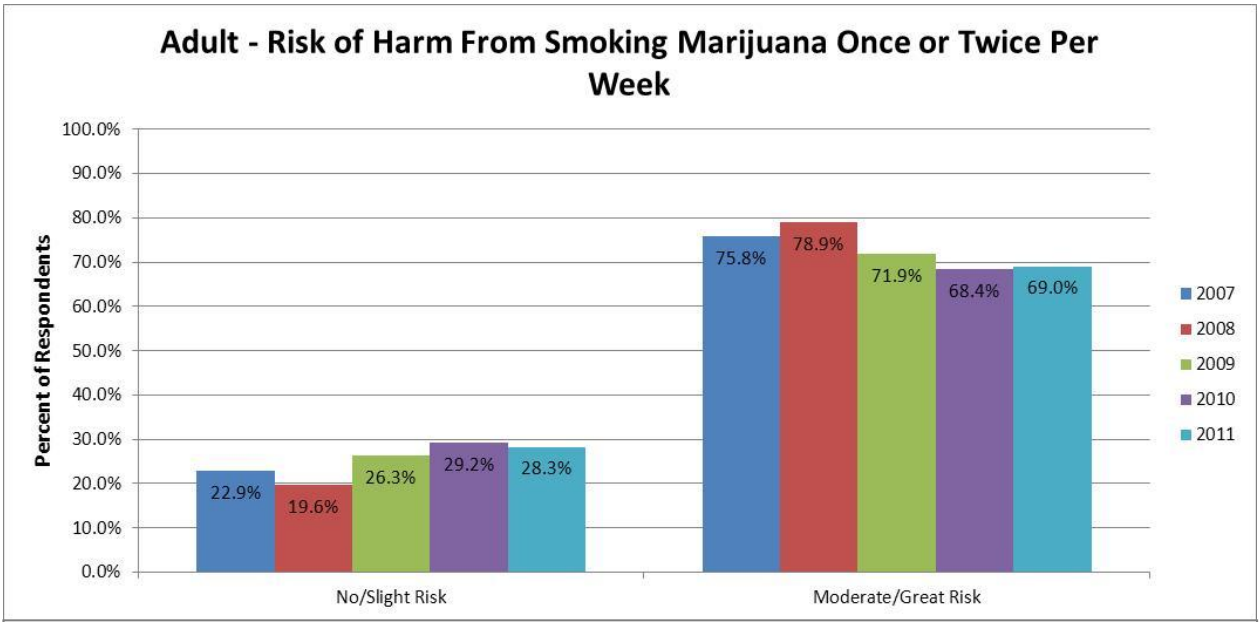
Question 02M: During the past 30 days, on how many days did you use marijuana or hashish?



* .48% (2007), .48% (2008), .67% (2009), .69% (2010) and 1.44% (2011) of survey respondents did not respond to this question.

The percentage of adults reporting no past 30 day use of marijuana or hashish has remained slightly above 90% for every year from 2007-2011. In 2011 7.8% of adults reported past 30 day use of marijuana or hashish.

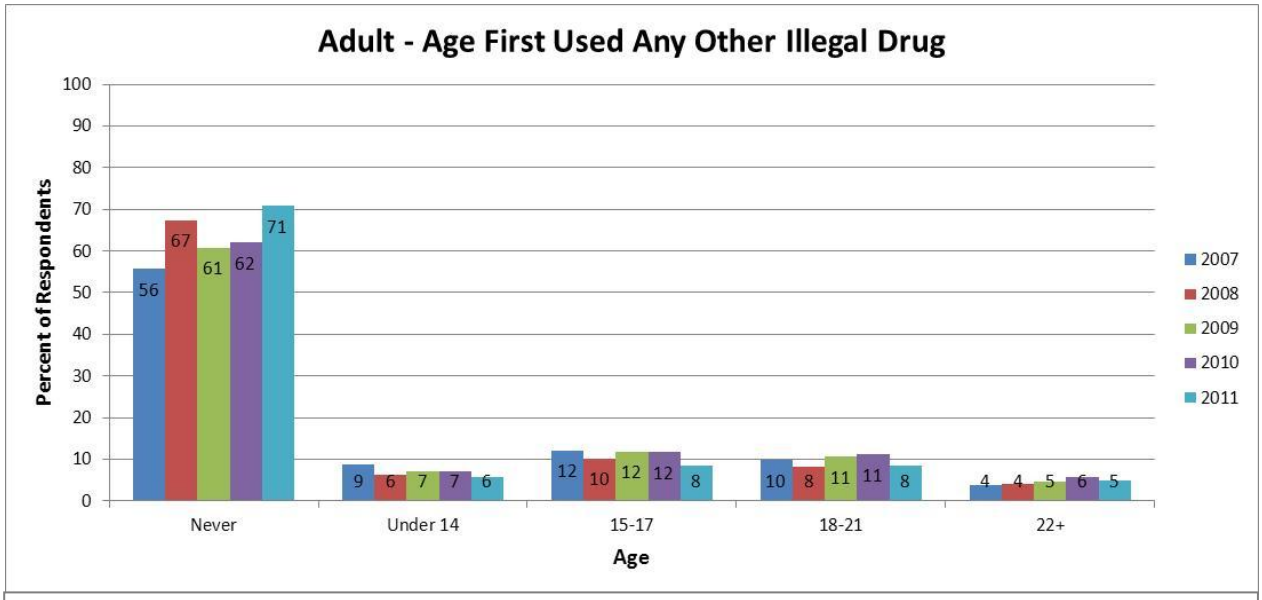
Question 03M: How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?



* .25% (2007), 1.46% (2008), 1.78% (2009), 2.35% (2010) and 2.67% (2011) of survey respondents did not respond to this question.

Adult perception of risk of smoking marijuana once or twice per week has shown an overall negative trend over the five years depicted above. The percentage of adults reporting moderate/great risk has decreased by approximately 7% from 2007 to 2011. Of the five questions on the survey regarding the potential harm posed by use of certain substances (i.e., cigarettes, marijuana, alcohol, prescription drugs and synthetic drugs), this question on marijuana use had the highest percentage of respondents reporting no or only slight risk.

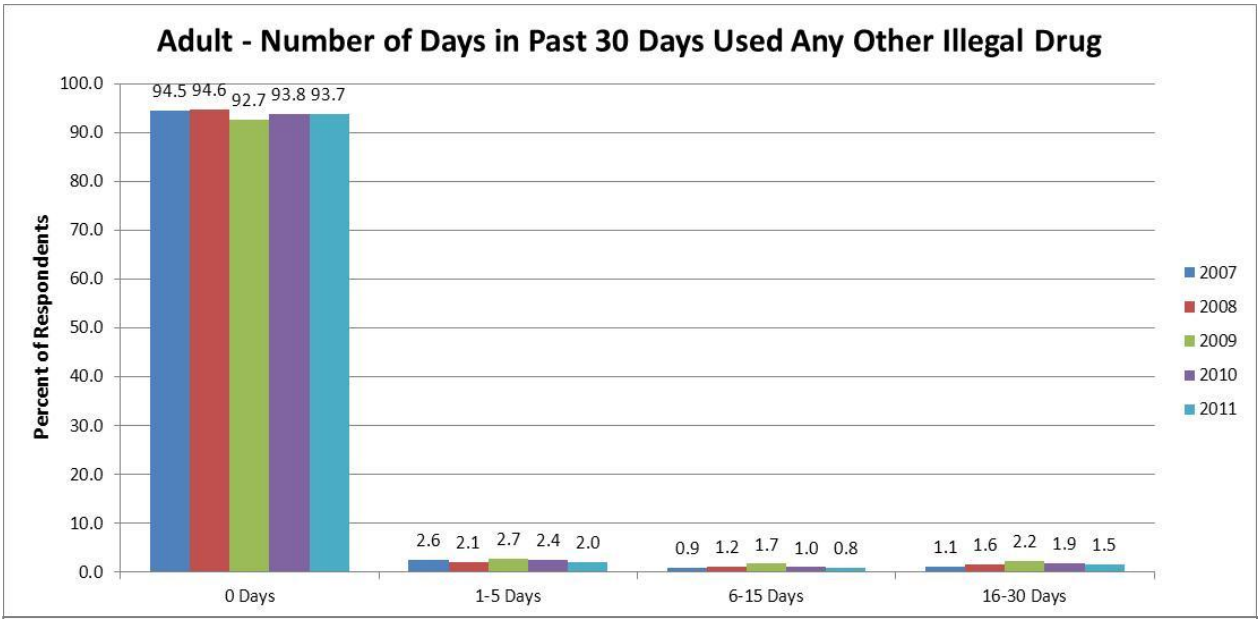
Question 01O: How old were you the first time you used any other illegal drug? Other illegal drugs include substances such as: Heroin, crack or cocaine, methamphetamine; Hallucinogens (such as LSD, Ecstasy, PCP or peyote); Inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid or shoe polish.



* 9.76% (2007), 3.88% (2008), 4.89% (2009), 2.56% (2010) and 1.66% (2011) of survey respondents did not respond to this question.

The percentage of adults reporting that they have never used any other illegal drug has fluctuated from 20007-2011, but has increased from 56% in 2007 to 71% in 2011. In 2011 approximately 27% of adults reported that they had used any other illegal drug. The most commonly reported age at first use was 15-17.

Question 01O: During the past 30 days, on how many days did you use any other illegal drug? Other illegal drugs include substances such as: Heroin, crack or cocaine, methamphetamine; Hallucinogens (such as LSD, Ecstasy, PCP or peyote); Inhalants or sniffed substances such as glue, gasoline, paint thinner, cleaning fluid or shoe polish.



* .92% (2007), .56% (2008), .67% (2009), .83% (2010) and 2.00% (2011) of survey respondents did not respond to this question.

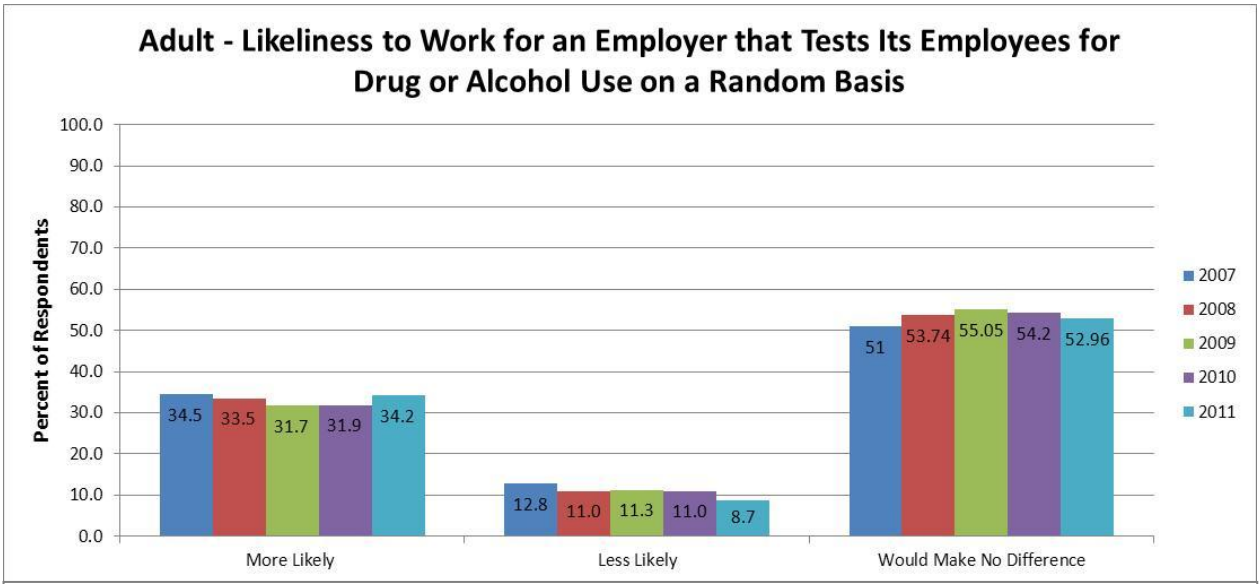
The percentage of adults reporting no past 30 day use of any other illegal drug has fluctuated slightly from 2007-2011, but has remained above 92% all five years. In 2011 4.3% of adults reported past 30 day use of other illegal drugs.

Question 01P: Have you ever taken prescription medications that were not prescribed specifically for you?
This question was added to the adult NOMs survey in 2011. 28.16% answered yes, 68.31% answered no and 3.51% did not answer.

Question 02P: How much do people risk harming themselves physically and in other ways when they take prescription medications not specifically prescribed for them?
This question was added to the adult NOMs survey in 2011. 11.28% answered no or slight risk, 84.77% answered moderate or great risk, and 3.91% did not answer.

Question 01S: How much do people risk harming themselves physically and in other ways using synthetic drugs?
This question was added to the adult NOMs survey in 2011. 9.22% answered no or slight risk, 86.53% answered moderate or great risk, and 4.21% did not answer. A question regarding perceived risk of harm was asked about five substances in 2011. Synthetic drugs had the second highest percentage (after cigarettes) of respondents selecting moderate or great risk.

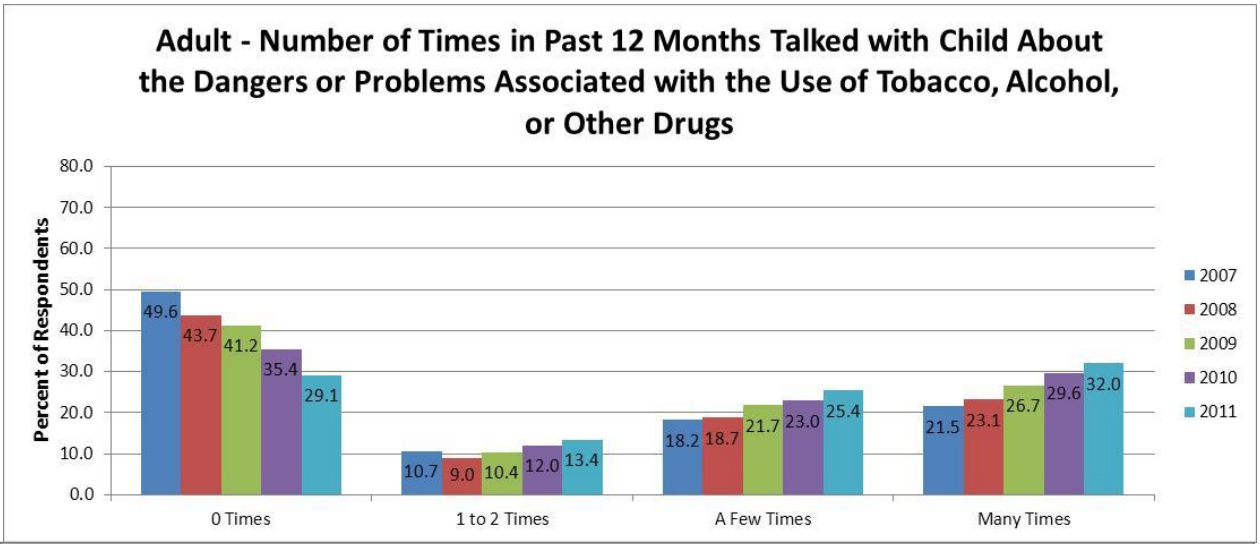
Question 01Z: Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis?



* 1.69% (2007), .48% (2008), 1.89% (2009), 2.84% (2010) and 4.13% (2011) of survey respondents did not respond to this question.

The percentage of adults reporting that they would be more likely to work for an employer that tests its employees for drug or alcohol use on a random basis has decreased from 2007-2009, but increased in 2011. Each year just over 50% of respondents reported that they would not be more likely or less likely to work for an employer that does random drug and alcohol tests.

Question 02Z: During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?



* The percentages in the graph above were calculated out of the total number of respondents who chose one of the four answer choices shown (n=2852 for 2007, n=3165 for 2008, n=3317 for 2009, n=3490 for 2010, n=2815 for 2011). Those who selected not applicable (no children or children are not age appropriate) or did not answer this question were not included in the denominator when calculating the percentages. The percent who selected Not Applicable and who did not respond, calculated out of the total number of respondents, is 9.32% (2007), 5.90% (2008), 30.39% (2009), 36.84% (2010) and 43.5% (2011).

The percentage of adults reporting that they have not talked with their child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs in the past 12 months has decreased steadily from 2007-2011. This has been accompanied by an increase in the number reporting that they talked with their child many times. In 2011 71% of respondents reported talking with their child at least once.

Data Analysis Compiled from the Client Information System (CIS)
State Fiscal Year 2011-2012

Licensed drug and alcohol treatment providers in Pennsylvania that receive federal, state or local funds from the Department of Drug and Alcohol Programs (Department) are required to report the treatment services they provide to the Department's Client Information System (CIS). Providers not receiving federal, state or local funds from the Department are not required to report to the CIS, although some do so voluntarily. Therefore, the statistics generated from CIS should not be interpreted as a complete representation of all drug and alcohol treatment services in Pennsylvania.

Admissions and Unique Clients

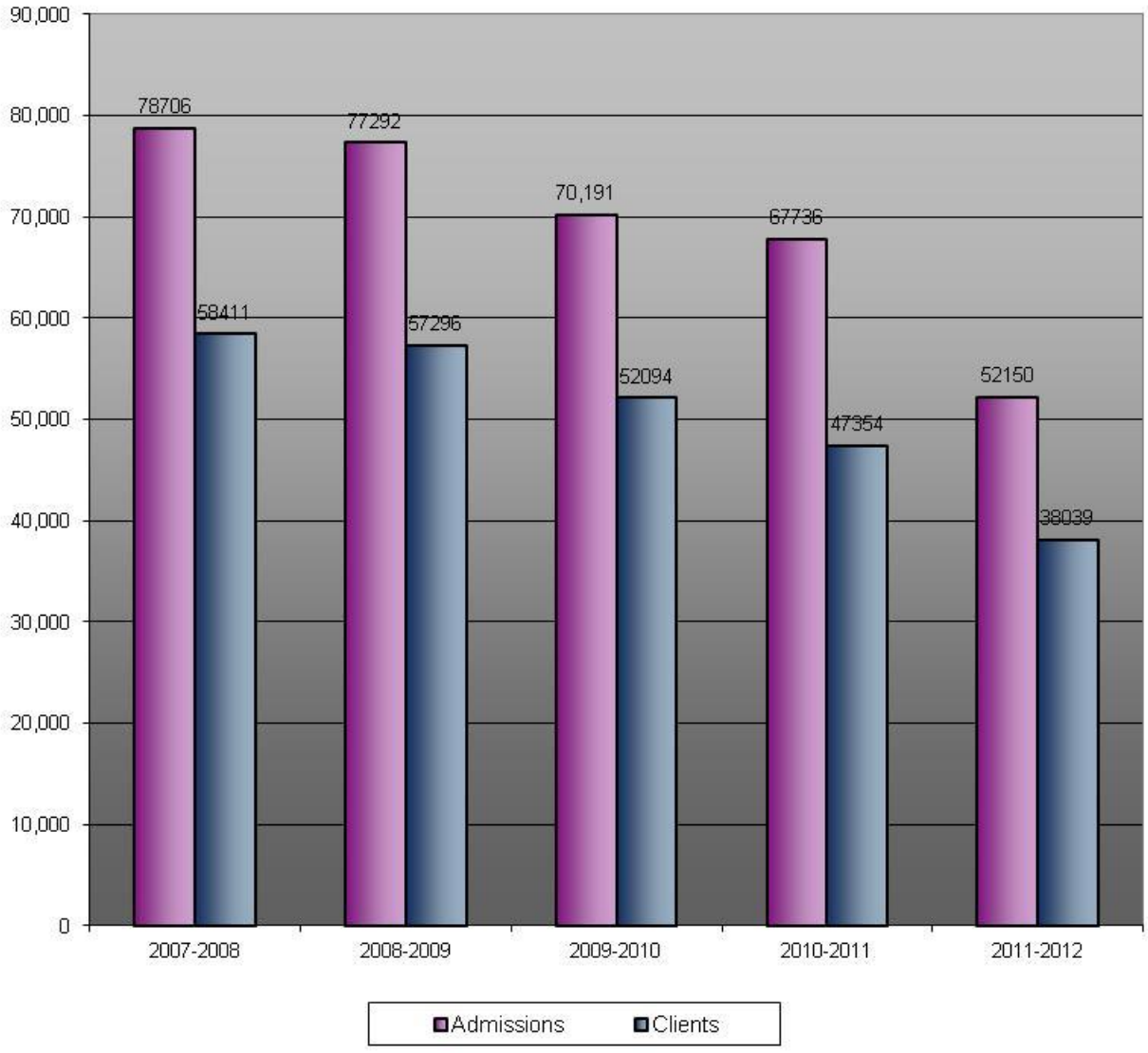
(Figure 1) shows total admissions and total unique clients served for the past five state fiscal years. A unique client is a single person who has been admitted and has received any substance abuse treatment at a licensed provider during the given state fiscal year. An admission occurs when a client is admitted to receive substance abuse treatment at a licensed provider. Each time a client receives a new type of service or goes to a new provider, he is discharged and a new admission occurs. Consequently, each unique client can have multiple admissions.

The graph shows that admission totals and unique client totals are closely related. Both totals change in a similar pattern. In the past five state fiscal years (2007-2008 through 2011-2012), reported admissions and clients have been on the decline.

This is not necessarily a direct reflection of a decrease in need for treatment or a decrease in the amount of services provided. The Single County Authorities (SCA)s and providers have reported treating fewer clients as a direct result of less funding to provide services. Also, the CIS is an old system and has become difficult to operate smoothly in the past few years. Many providers are using new operating systems that are causing compatibility problems. Therefore, this decline may be more of a reflection of data transfer issues and under-or non-reporting from some providers. The Department is in the process of remedying these issues.

Figure 1

CIS Admissions and Unique Clients* for State Fiscal Years 2007-2008 through 2011-2012



*Clients are unique admissions counted once in the time period.

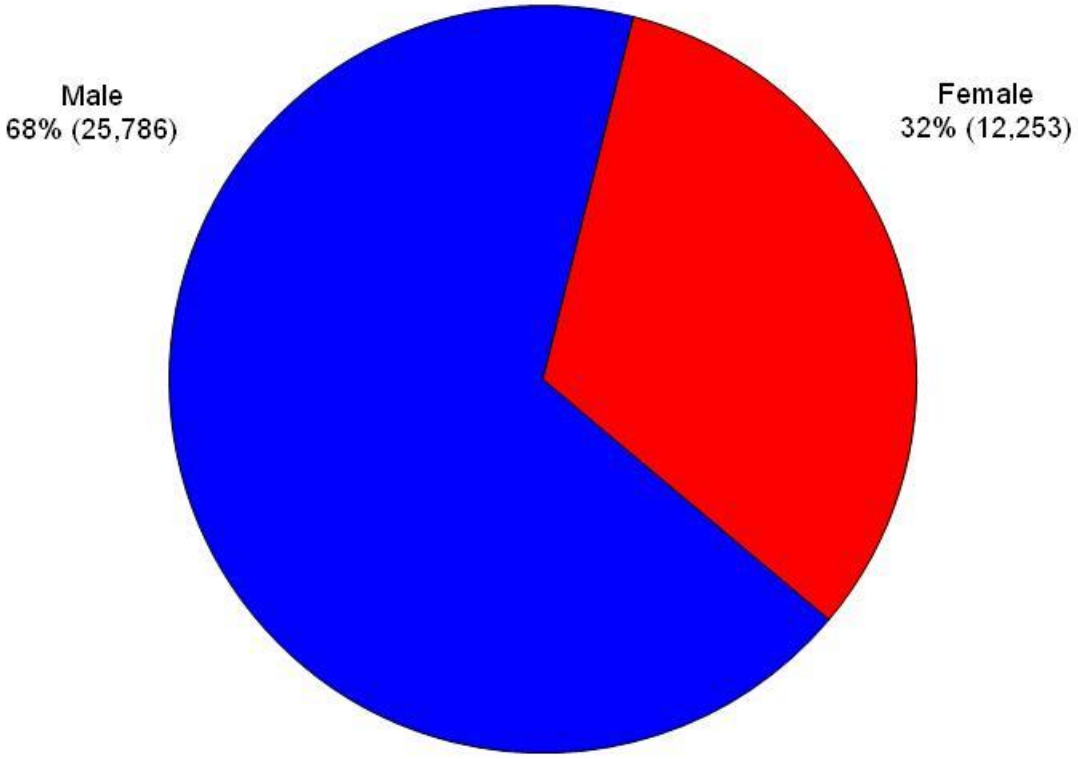
Client Demographics

Clients that are treated by programs funded by the Department are quite different from the general population in many ways. The following charts and narrative describe these differences. The majority (68%) of clients is male (Figure 2), while the general population is 49% male. Well over half (60%) of all clients are in the 15-34 year old age group (Figure 3). There is a slightly higher percentage of African-American clients in treatment compared to the total Pennsylvania population of African-Americans (13% and 11.3%, respectively). (Figure4). There is a similar percentage of Hispanics in treatment compared to the general population (6% and 5.9%, respectively) (Figure 5). Nearly one in five (18%) clients in treatment is of unknown ethnicity (Figure 5), so the percentage of Hispanic clients in treatment may actually be higher. All Pennsylvania population percentages are from the 2011 Pennsylvania State Data Center Estimates. There have been no significant changes concerning state client demographics over the last three fiscal years.

Figure 2

CIS Unique Client Admissions SFY 2011-2012

Gender

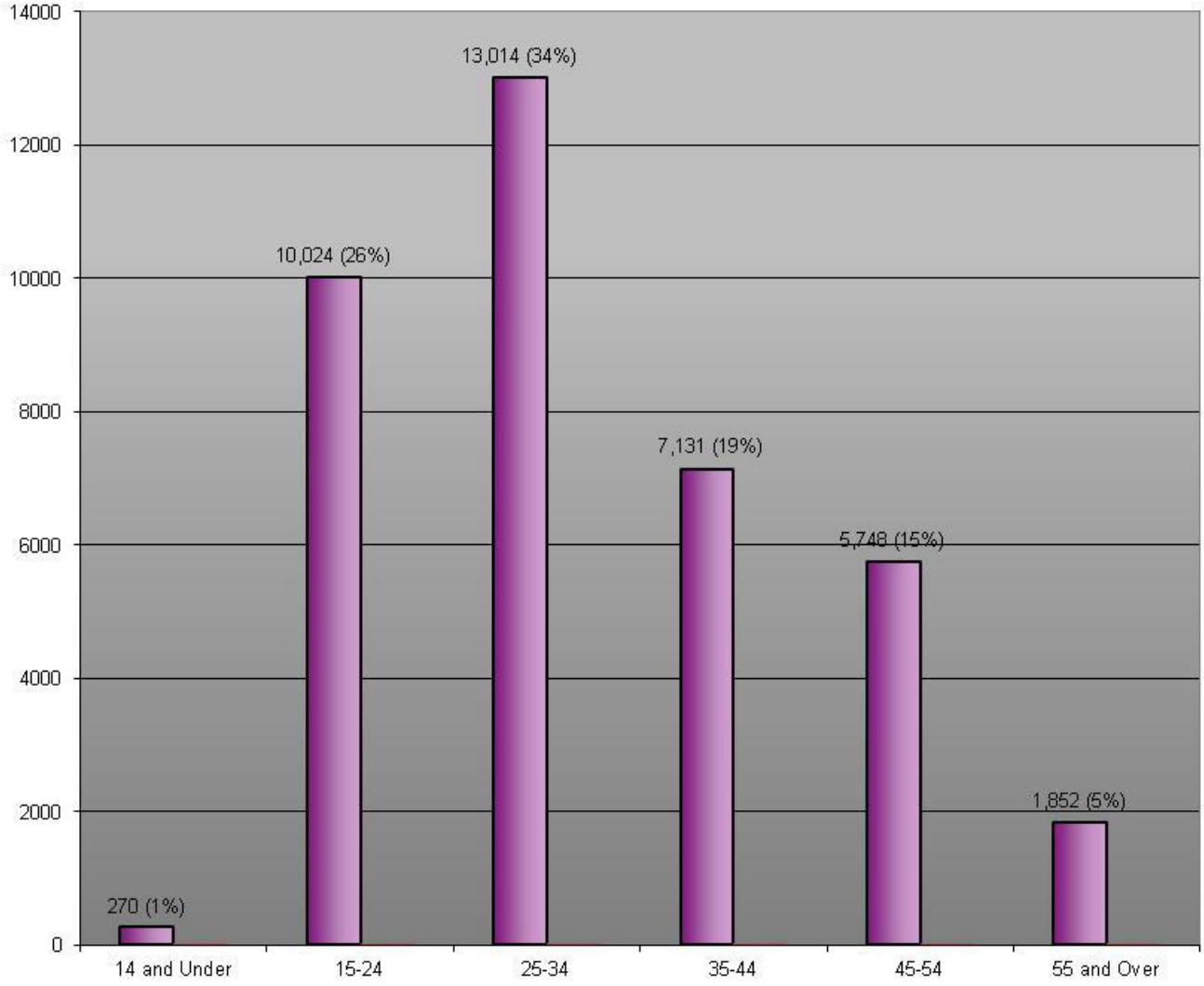


Clients are unique admissions counted once in the time period.
Total Clients=38,039

Figure 3

CIS Unique Client Admissions SFY 2011-2012

Age Groups

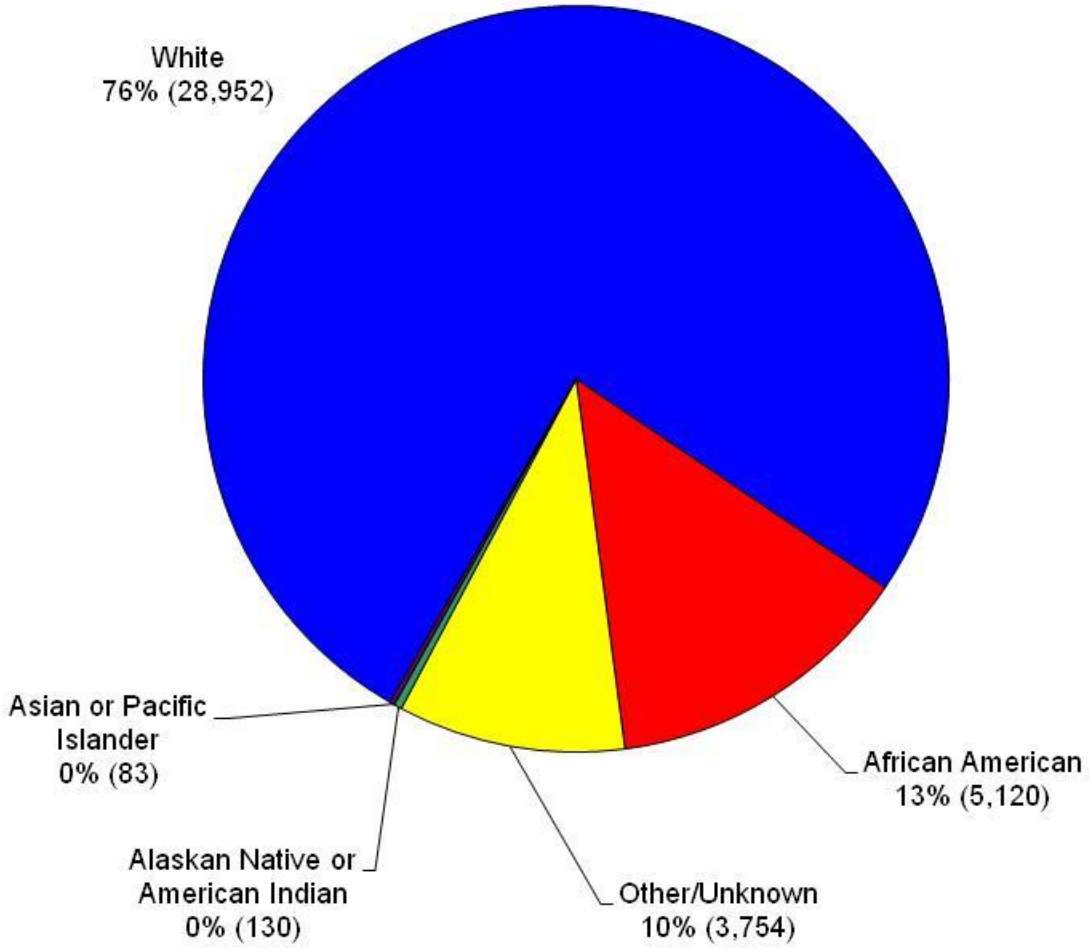


Clients are unique admissions counted once in the time period.
Total Clients=38,039

Figure 4

CIS Unique Client Admissions SFY 2011-2012

Race

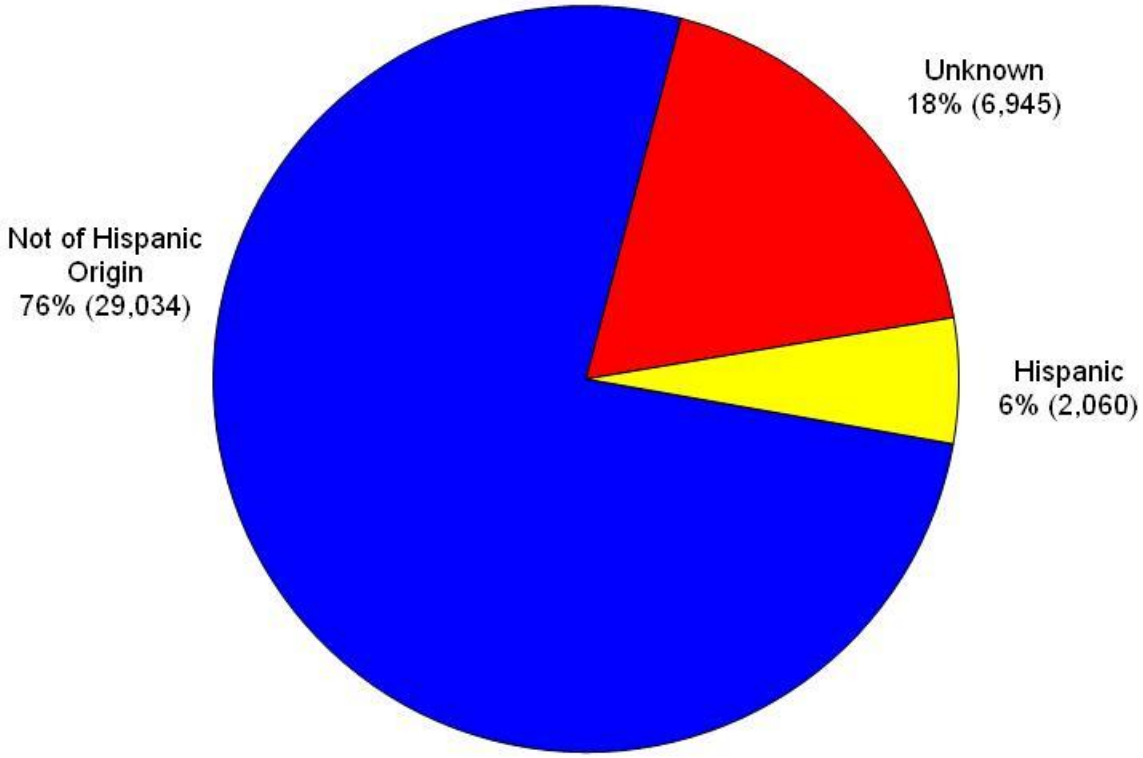


Clients are unique admissions counted once in the time period.
Total Clients=38,039

Figure 5

CIS Unique Client Admissions SFY 2011-2012

Ethnicity



Clients are unique admissions counted once in the time period.
Total Clients=38,039

Admissions Characteristics

The Department is a payer of last resort, and many clients are unable to pay for the substance abuse treatment services they require. Therefore, many of these clients are at other disadvantages in addition to their substance abuse issues. The following charts and narratives describe some of these other disadvantages reported by clients during admission to substance abuse treatment.

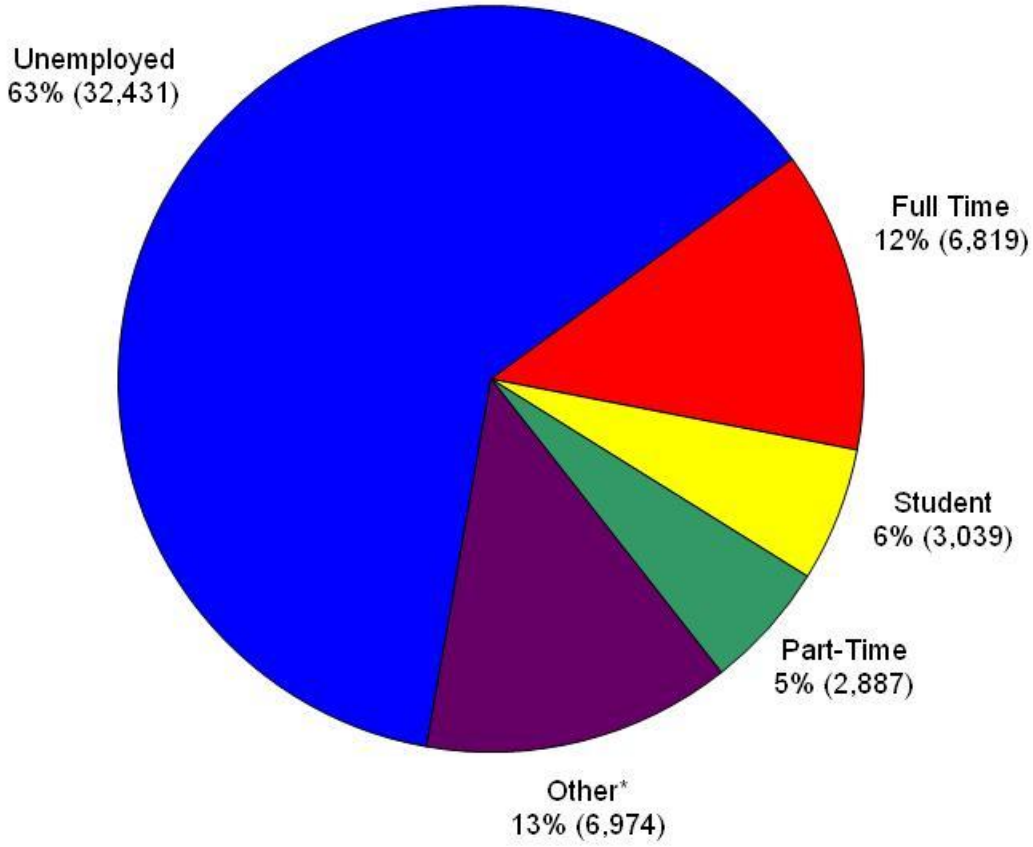
The majority (63%) of clients reported being unemployed. In addition, only 1 in 8 clients reported being employed on a full-time (12%) or even fewer on a part-time (5%) basis. The remaining admissions were of other employment statuses (Figure 6). Nearly three-fourths (74%) have never been married. Only 9% of clients were married when they were admitted. The remaining clients reported their status as divorced (11%), separated (5%) or widowed (1 %) (Figure 7). Nearly one third (33%) of clients were admitted under non-voluntary circumstances (Figure 8). This means they were involved in the criminal justice system, and substance abuse treatment was mandated. Trending this data over the last three fiscal years, there have been no significant changes concerning state client admission characteristics.

All of these characteristics show that AOD clients face considerable obstacles beyond substance abuse. The lack of employment, family support and the high rate of involvement in the criminal justice system all present additional difficulties that many of these clients face.

Figure 6

CIS Admissions SFY 2011-2012

Employment Status

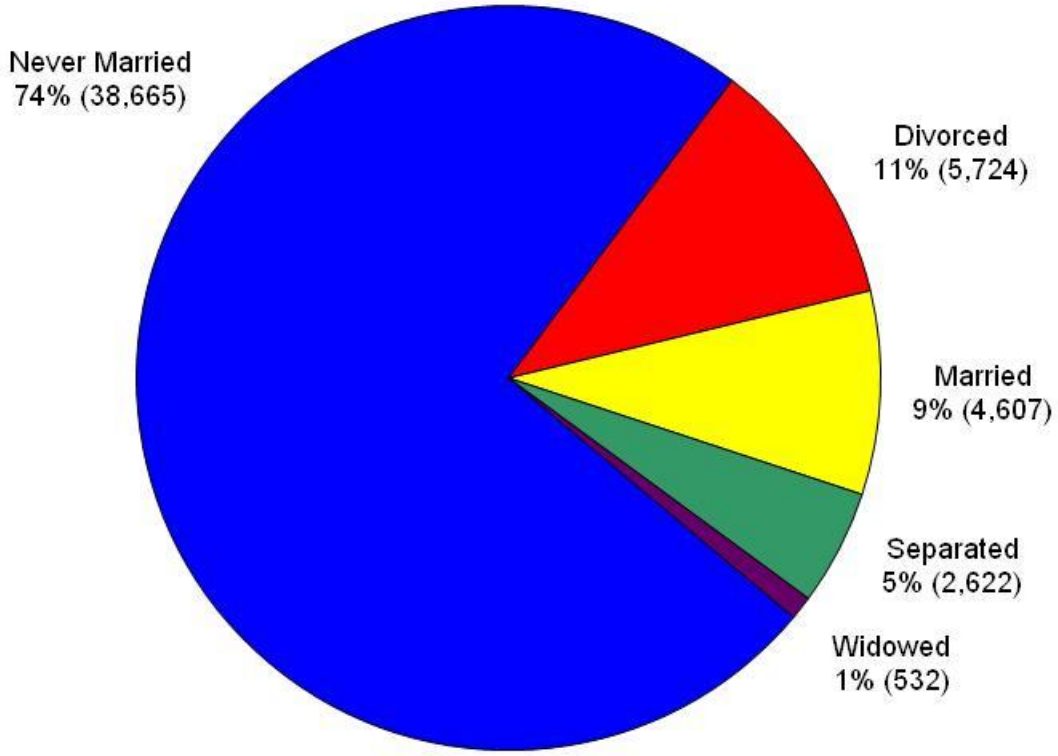


*Other includes: Disabled, Leave of Absence, Retired, Homemaker, Armed Forces, Unknown, and Other Employment Status.
Total Admissions=52,150

Figure 7

CIS Admissions SFY 2011-2012

Marital Status

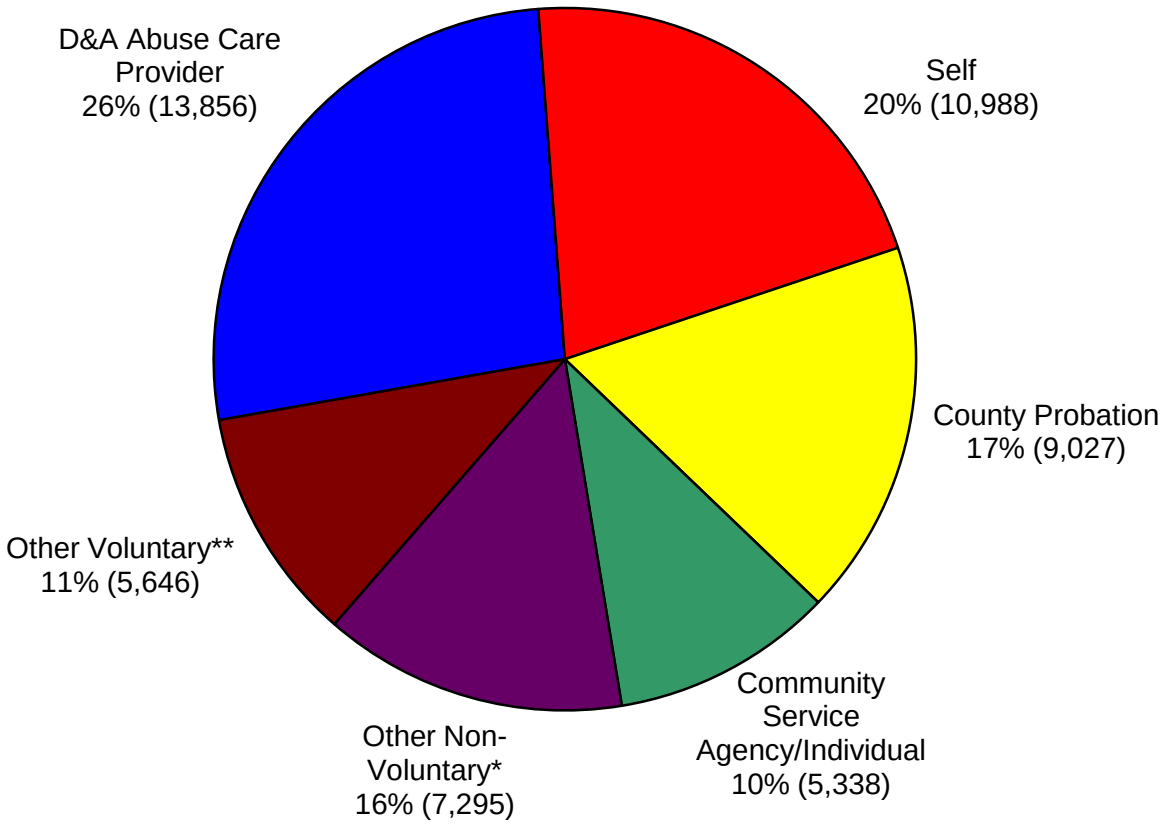


Total Admissions=52,150

Figure 8

CIS Admissions
SFY 2011-2012

Referral Sources

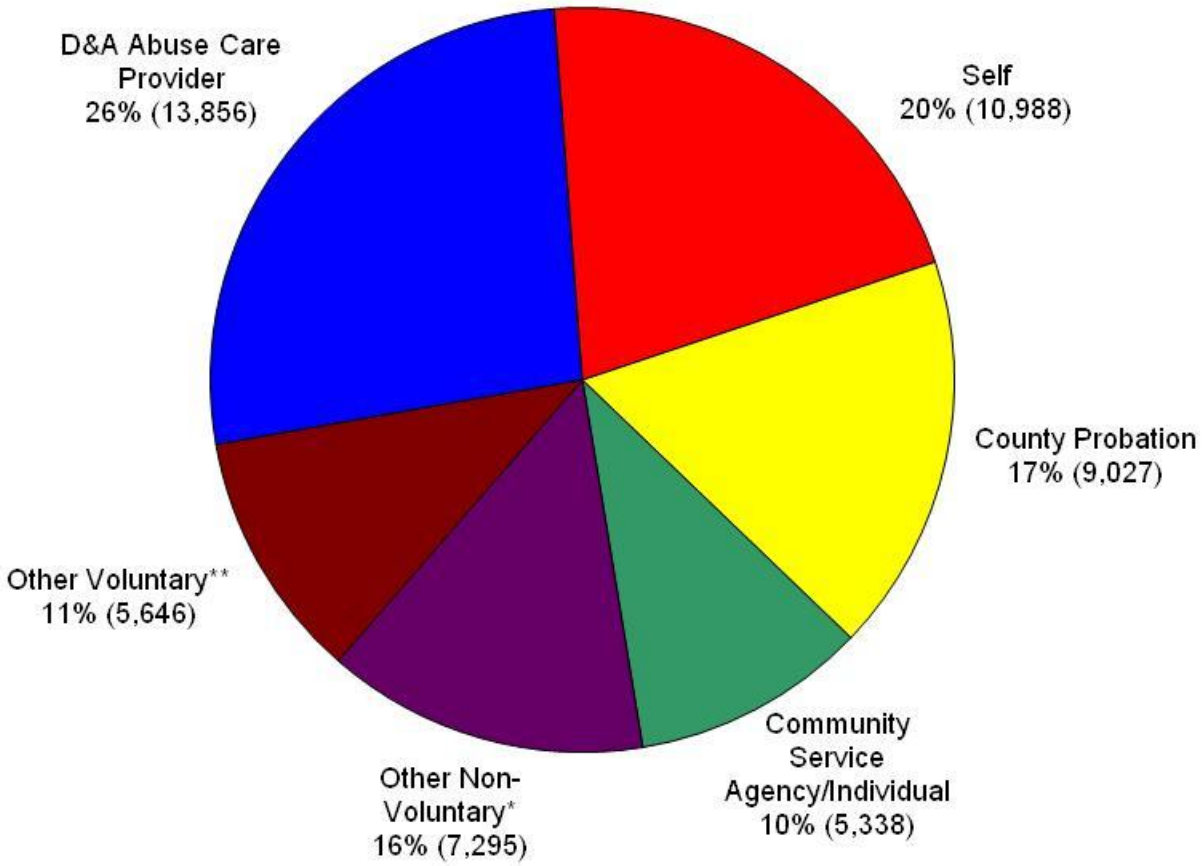


*Other Non-Voluntary includes: Court (Judge), Federal Parole, State Parole, County Parole, Federal Probation, State Probation, and Other Non-Voluntary.
**Other Voluntary includes: Hospital/Physician, Family/Friend, School, Diversion Programs, Employer/EAP, Clergy/Religious, and Other Voluntary.
Total Admissions=52,150

Figure 8

CIS Admissions SFY 2011-2012

Referral Sources



*Other Non-Voluntary includes: Court (Judge), Federal Parole, State Parole, County Parole, Federal Probation, State Probation, and Other Non-Voluntary.
**Other Voluntary includes: Hospital/Physician, Family/Friend, School, Diversion Programs, Employer/EAP, Clergy/Religious, and Other Voluntary.
Total Admissions=52,150

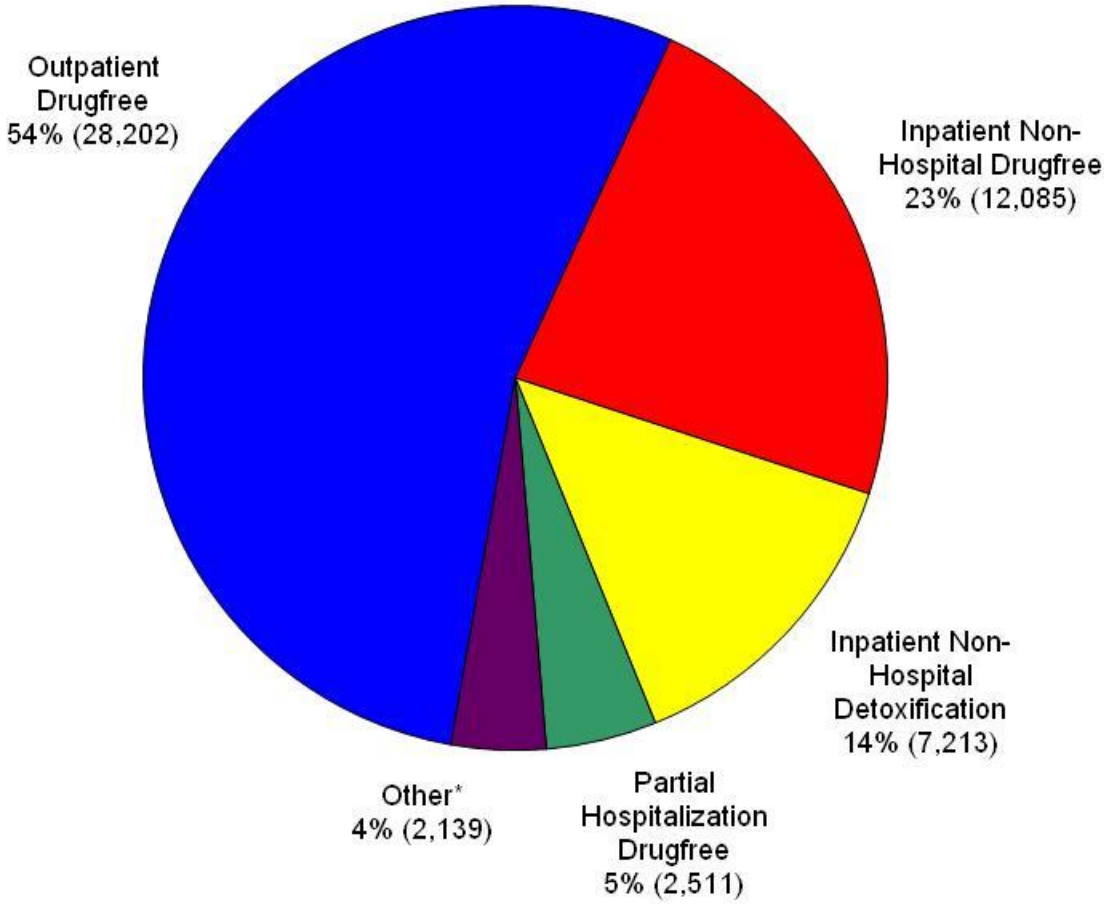
Types of Treatment

There are several different types of treatment available to clients in Pennsylvania. Treatment modality usage varies widely by SCA, so these statewide figures may not give an accurate representation of local area modality utilization. The most prevalent type of treatment received is of the Outpatient Drug-free type, with 54% of clients receiving this modality (Figure 9). This is also the least intensive, most inexpensive modality. Nearly a quarter (23 %) of admissions was of the Inpatient, Non-Hospital Drug-free type. Such treatment is more intensive, with the client living and receiving treatment services at the facility. There have been no significant changes concerning treatment modalities trend data over the last five fiscal years.

Figure 9

CIS Admissions SFY 2011-2012

Treatment Modalities



*Other includes: Correctional Institution: Detox, Drug Free, Experimental. Inpatient Hospital: Detox, Drug Free, Experimental, Other Chemotherapy. Inpatient Non-Hospital: Experimental, Other Chemotherapy. Outpatient: Detox, Experimental, Maintenance, Other Chemotherapy. Partial Hospital: Detox, Experimental, Other Chemotherapy. Shelter: Drug Free, Experimental.
Total Admissions=52,150

Patterns of Drug Use

Clients are admitted to treatment for a wide range of primary substances of abuse. Different groups of clients also use very different types of substances. The following charts and narrative illustrate these points. The most common primary substance of abuse is alcohol (35%). Heroin (24%), marijuana/hashish (14%), cocaine/crack (8%) and other opiates/synthetics (13%) these primary substances account for 94% of admissions. The remaining 6% is composed of other drugs (Figure 10).

There has been little overall change in the primary drugs reported over the past five State Fiscal Years (Figure 11). Since State Fiscal Year 2009-2010, heroin is steadily rising as a primary substance being abused increasing from 20% respectively to 23.5%. As of 2011-2012, marijuana/hashish has reported as trending downward for the past four years. The only drug category that has shown substantial and consistent growth in over the past five years is the other opiates/synthetics category (Figure 12). In State Fiscal Year 2007-2008, this category accounted for 7.6% of admissions. In State Fiscal Year 2011-2012, it accounted for 13% of admissions.

Admissions for particular primary drugs of abuse vary by gender, race, ethnicity and age group. Males are admitted for alcohol use more frequently (37%) than females (30%), as well as more frequently for marijuana/hashish (16% and 11%, respectively). Females are admitted for cocaine/crack use more frequently (11%) than males (7%). Females are also admitted more often for other opiates/synthetics (16%) than males (12%). Both genders admitted for heroin use are increasing and heroin is the second most reported primary substance abused (females at 25% and males at 23%, respectively)(Figure 13).

Whites were admitted for alcohol use more frequently than African-Americans (34% and 33 %), more than three times as frequently for heroin (26% and 7%) and five times more frequently for other opiates/synthetics (15% and 3%). African-Americans were admitted over three times as often for cocaine/crack than whites (21% and 6%) and almost 3 times more frequently for marijuana/hashish (29% and 11%) (Figure 14).

Non-Hispanics were admitted for alcohol more frequently than Hispanics (37% and 34%) and over four times as frequently for other opiates/synthetics (13% and 3%). Hispanics were admitted more frequently for heroin than Non-Hispanics (24% and 19%). While the Hispanic percentage of admissions remained unchanged, there was a 2% reduction in Non-Hispanics reported for cocaine/crack (Hispanics at 10% and Non-Hispanics at 8%, respectively) (Figure 15).

Primary drugs of choice also vary quite significantly among age groups (Figure 16). Use of alcohol increases with age: the older the client is at admission, the higher the percentage of individuals who reported alcohol as their primary drug of choice. Marijuana/hashish is similar, but the relationship is the “inverse” the older the client is at admission, the lower the percentage who reported marijuana/hashish as their primary drug of choice. The percentage using the remainder of the drug categories peaks at an age group near the middle of the age distribution. Heroin begins this pattern earlier than crack/cocaine.

The age group 14 and under is admitted for marijuana/hashish use most frequently (55%), although this age group accounts for less than 1% of admissions. Many in this age category receive services through programs not reported in the CIS. Clients in this age group are of particular interest, because they require more specialized services oriented towards youth.

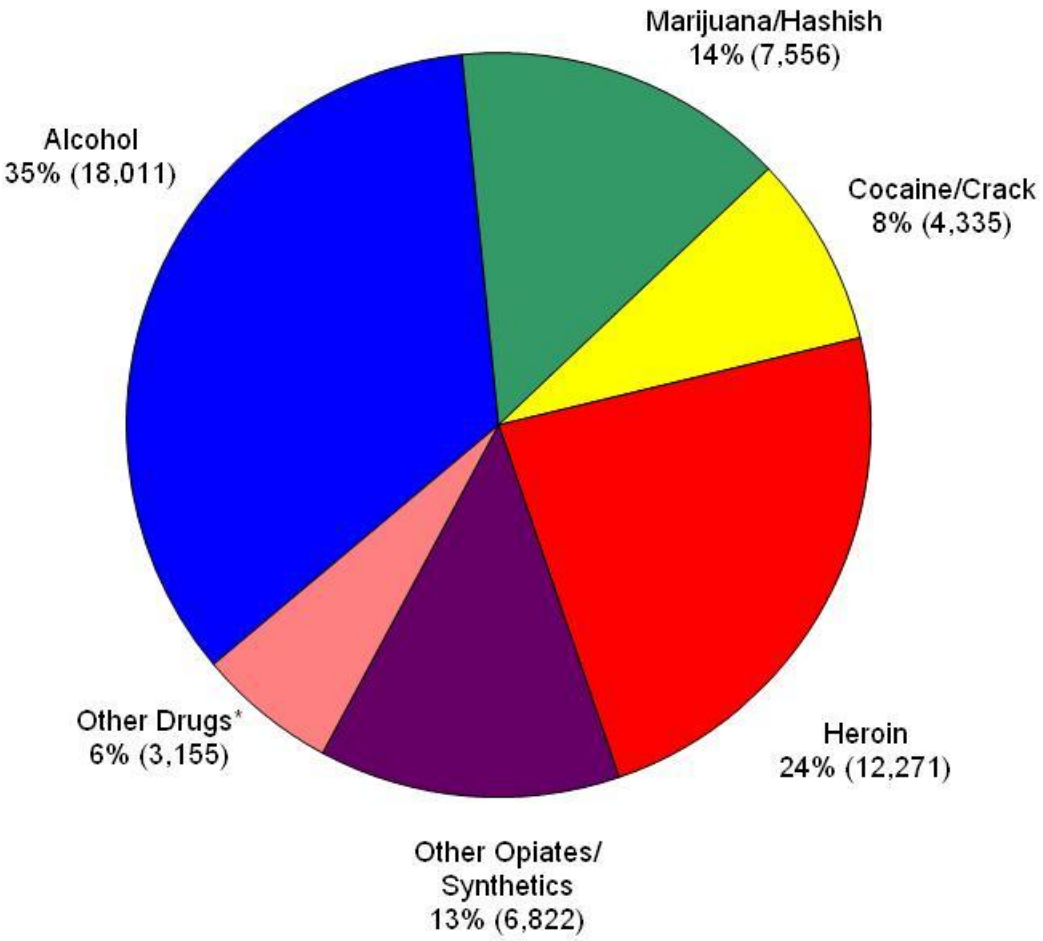
The age group 15-24 is also of particular interest, due to the transitional nature of this age category (Figure 17). The total admissions for this age group has been further broken down into ages 15-17 (2,130 admissions), 18-20 (3,169 admissions) and 21-24 (7,684 admissions).

Marijuana/hashish is the most prevalent drug of choice for the groups 15-17 and 18-20 (67% and 41%, respectively), but marijuana/hashish usage decreases by 49% between these two age groups as a person becomes progressively older. It decreases to 18% of all admissions in the 21-24 age groups. Heroin begins to be seen much more in the 18-20 age groups (19%), and for age group 21-24, heroin makes up an even higher percentage (31%) of admissions.

Figure 10

CIS Admissions
SFY 2011-2012

Primary Drug of Choice

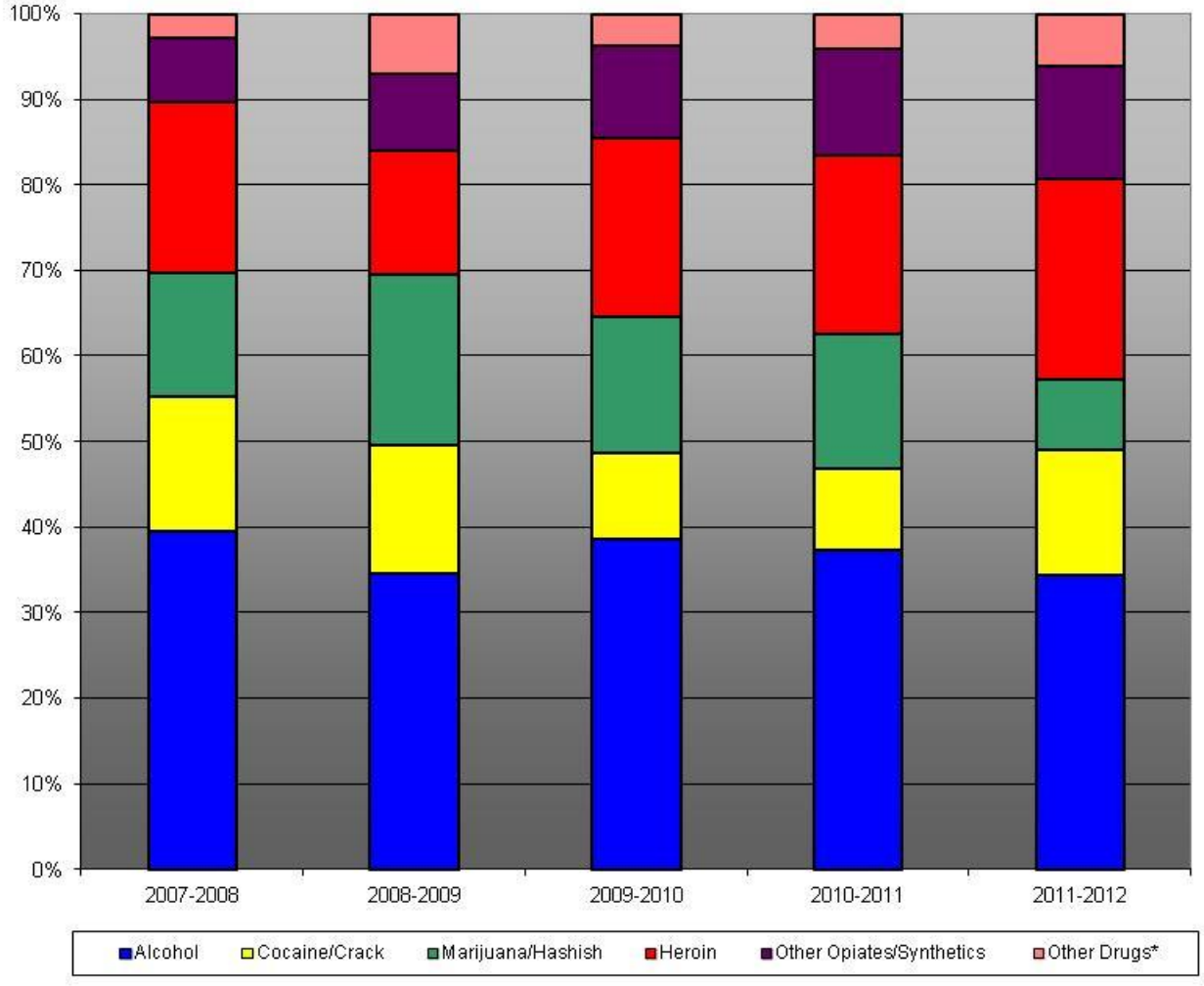


*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions=52,150

Figure 11

CIS Admissions for State Fiscal Years 2007-2008 through 2011-2012

Primary Drug of Choice



*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs

Figure 12

CIS Admissions for Other Opiates/Synthetics State Fiscal Years 2007-2008 through 2011-2012

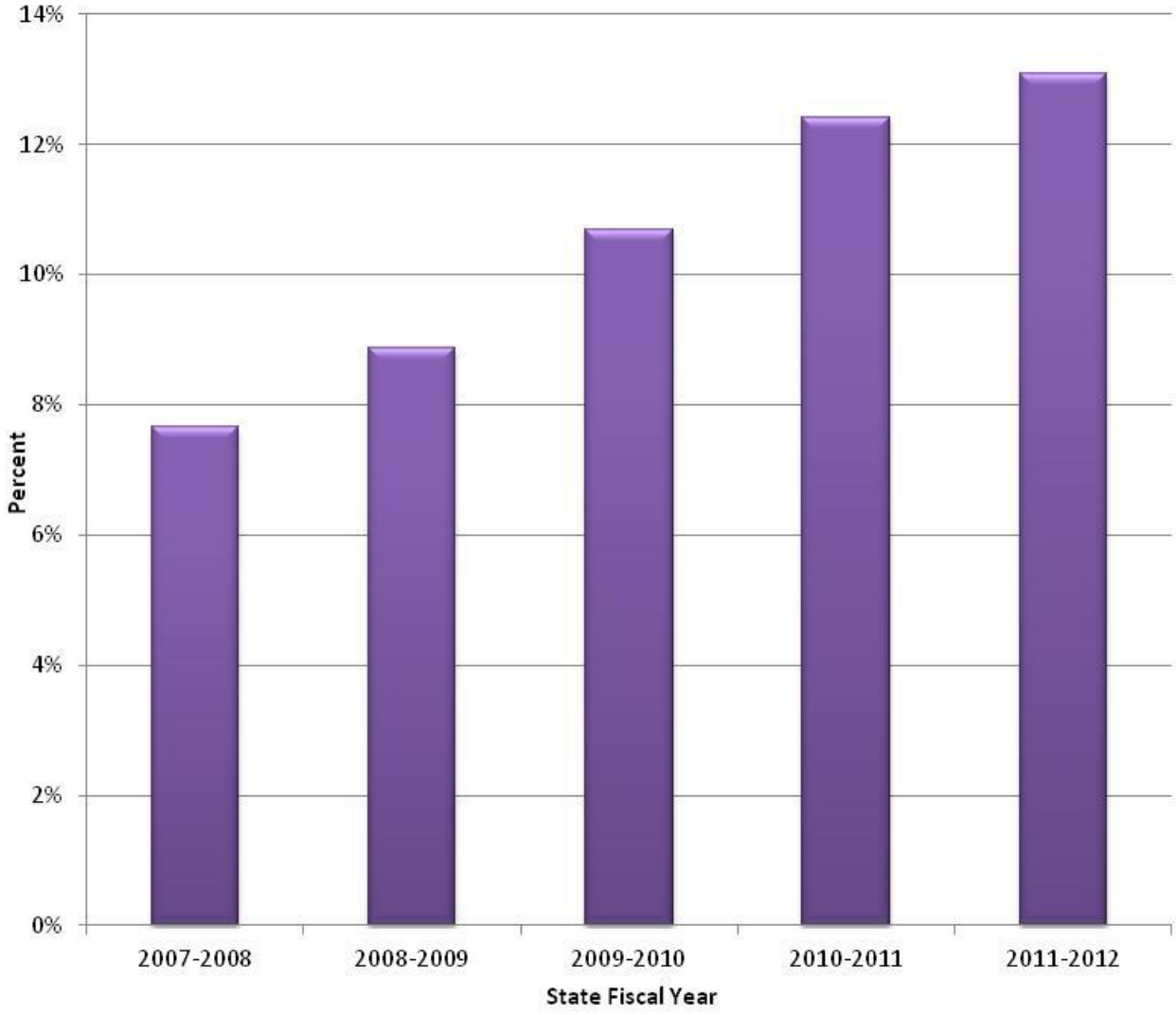
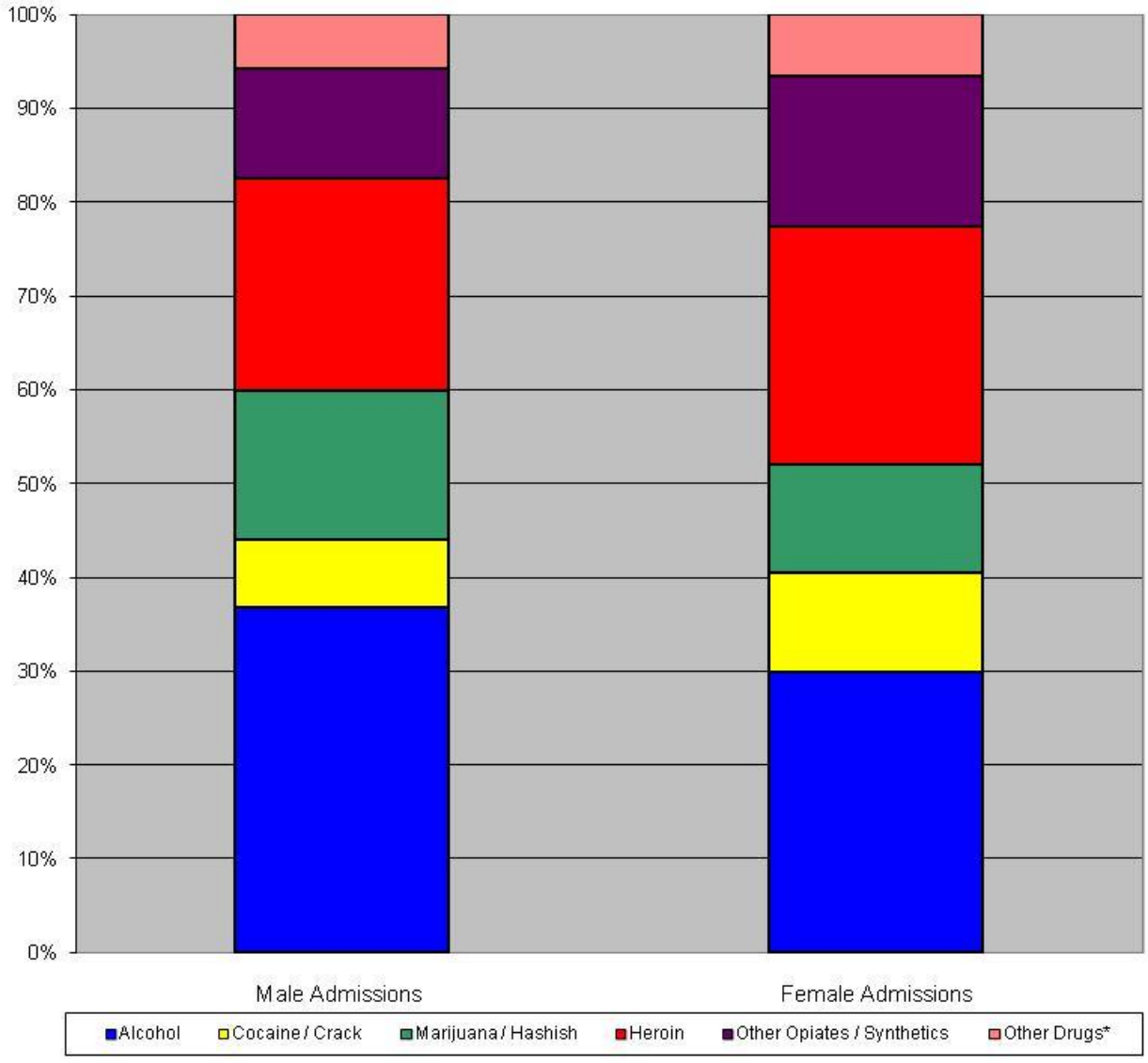


Figure 13

CIS Admissions
SFY 2011-2012

Primary Drug of Choice by Gender

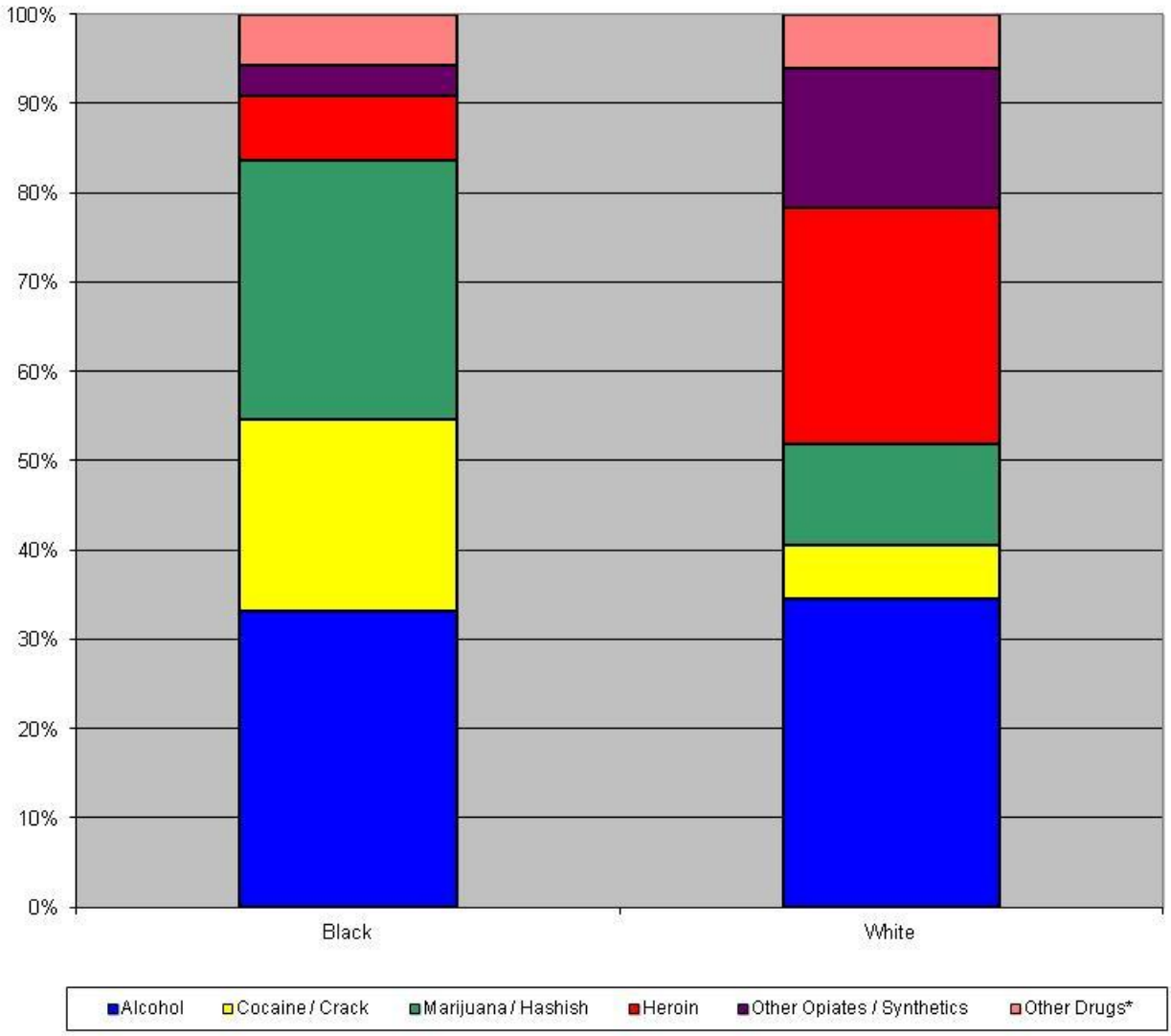


*Other Drugs includes: Other Opiates/Synthetics, Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions=52,150

Figure 14

CIS Admissions
SFY 2011-2012

Primary Drug of Choice by Race

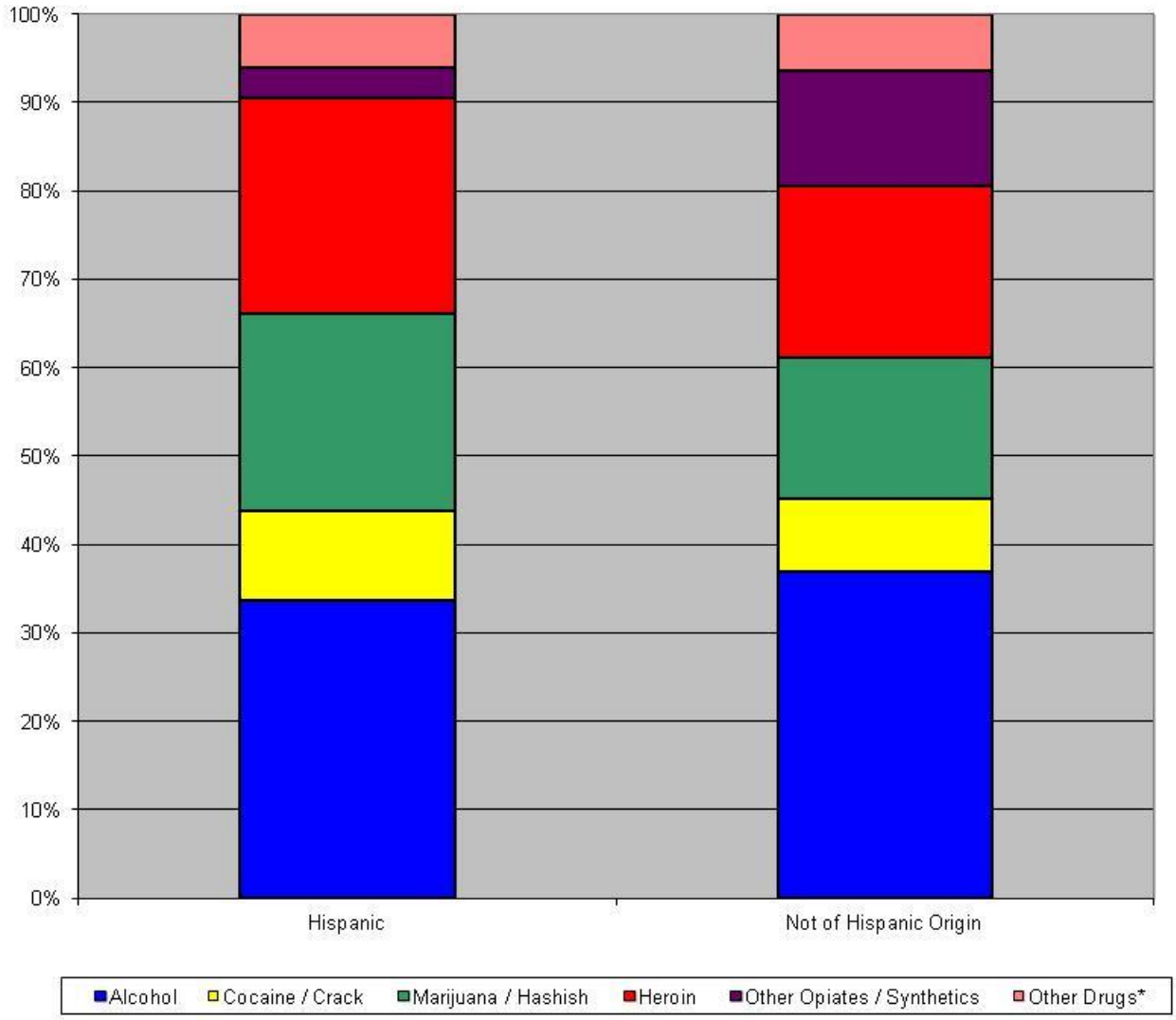


*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions for Black and White=47,040 (90% of Total Admissions)

Figure 15

CIS Admissions
SFY 2011-2012

Primary Drug of Choice by Ethnicity

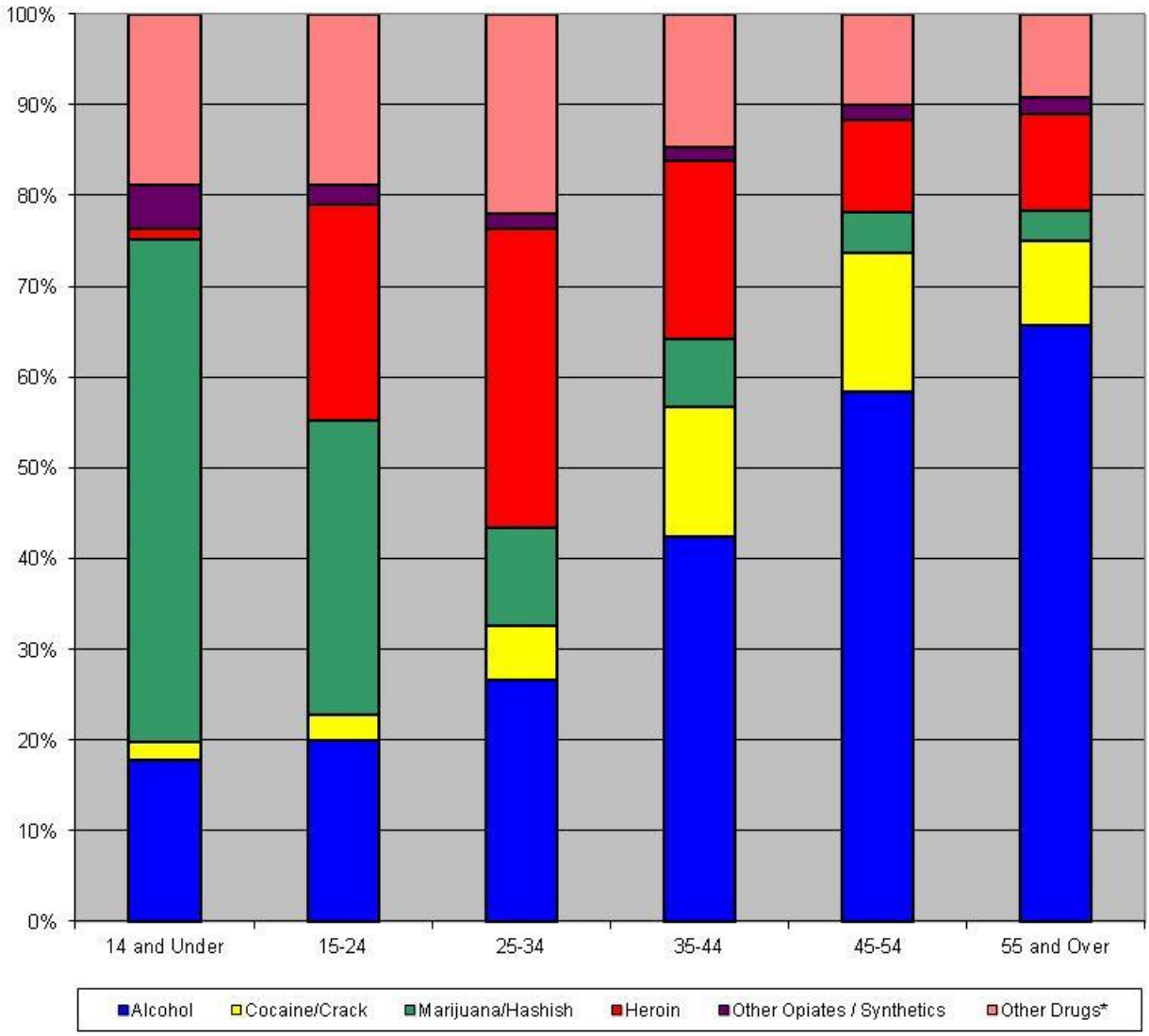


*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions for Hispanic and Not of Hispanic Origin=31,094 (82% of Total Admissions)
The remaining 6,945 admissions are of unknown ethnicity.

Figure 16

CIS Admissions
SFY 2011-2012

Primary Drug of Choice by Age Group



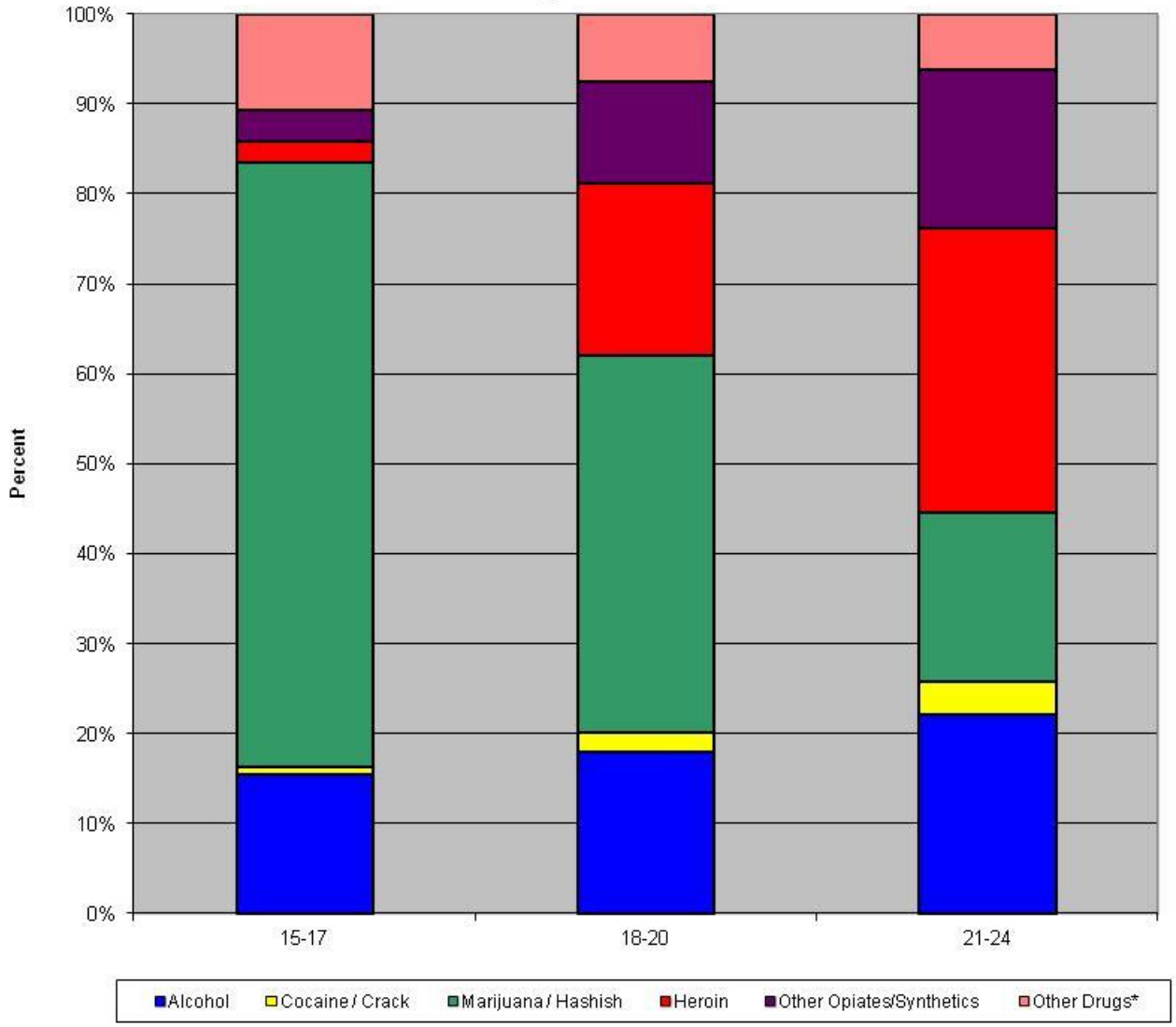
*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions=52,150

Figure 17

CIS Admissions
SFY 2011-2012

Primary Drug of Choice by Age Group

Ages 15-24



*Other Drugs includes: Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs.
Total Admissions=12,983

Discharges

When a client has completed a particular type of treatment or changes treatment providers, a discharge record is submitted to the CIS with an associated reason for discharge. There are two main types of discharges: detoxification and non-detoxification. The kind of service rendered in detox and non-detox treatments is very different, so there are different reasons for being discharged from the two categories. The following discharge data is associated with admissions that occurred in state fiscal year 2011-2012. No significant changes occurred from previous years. Therefore, no trend data has been presented.

After detox treatment was completed, 42% of patients were either transferred within the facility or were referred to another facility for drug and alcohol treatment. However, 41% completed their detox and were not transferred (Figure 18).

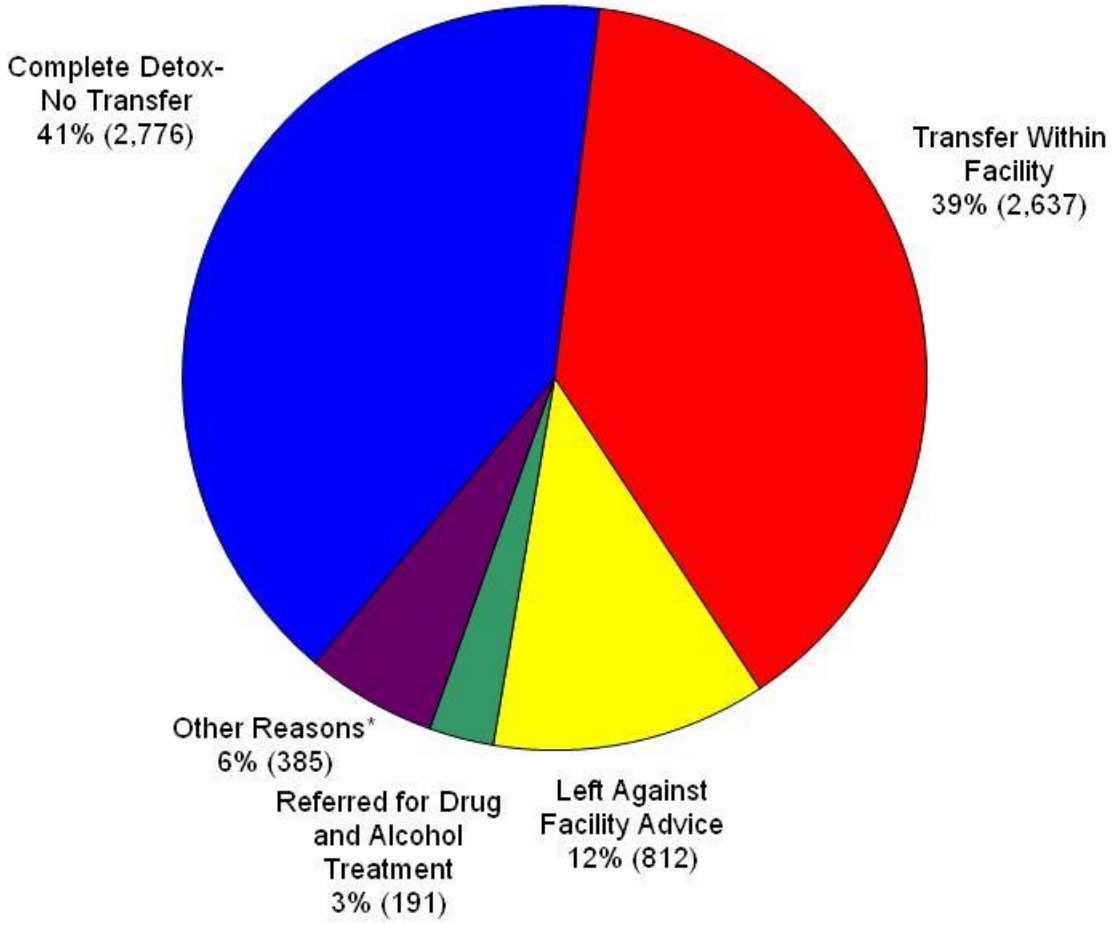
Upon entering treatment, each client and the provider work together to come up with a personalized treatment plan. This plan details the goals the client and provider agree upon, as well as how they plan to accomplish them. Pennsylvania does not consider total abstinence to be the only goal of treatment. A client can make significant progress at a specific level of care, even though there is still some substance use. Completing the goals of the treatment plan is the main aim of the substance abuse treatment providers.

Half (50%) of those discharged from non-detox treatment completed their treatment and had not used substances (Figure 19). For those who completed treatment (97%) did so with no drug use, while (3%) completed with some drug use (Figure 20).

Figure 18

CIS Discharges SFY 2011-2012

Detox Reasons for Discharge

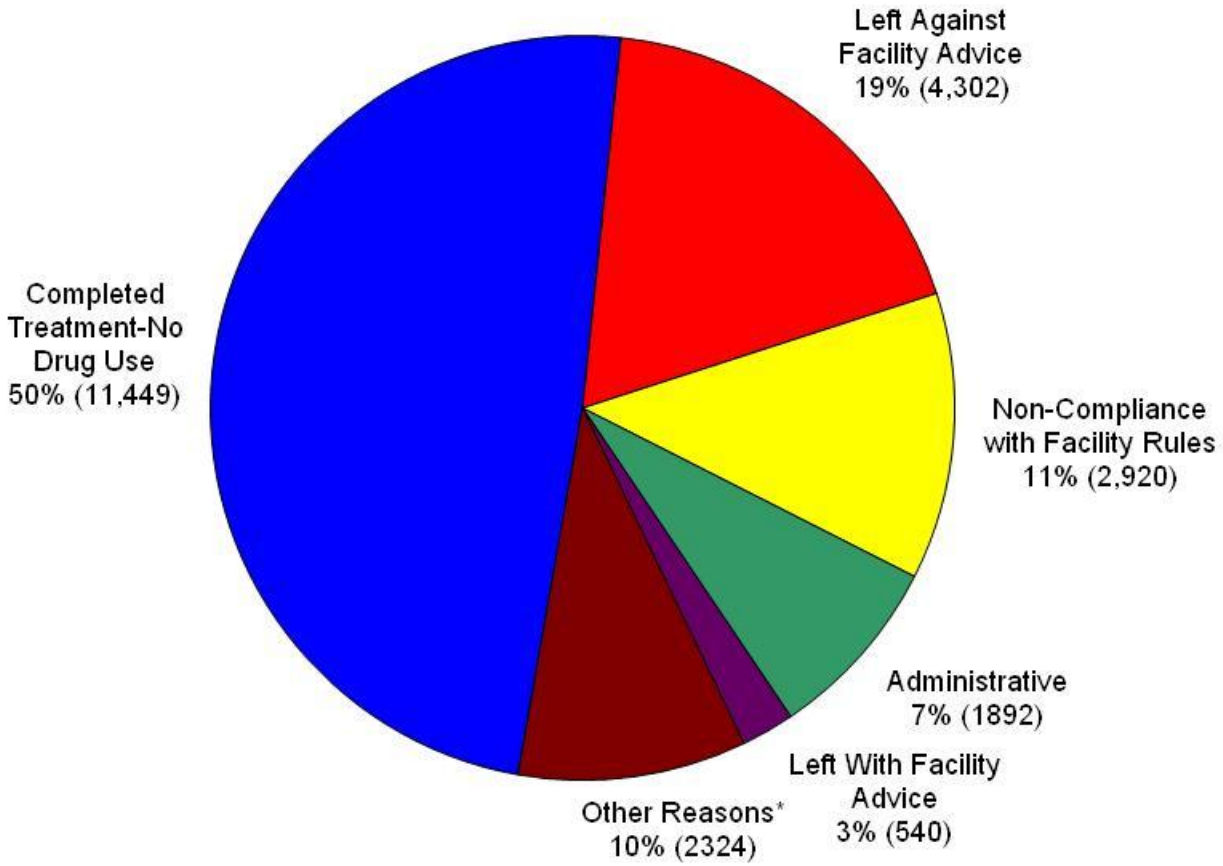


*Other Reasons includes: Left with Facility Advice, Non-Compliance with Facility Rules, Jailed and Death.
Total Discharges=6,801

Figure 19

CIS Discharges
SFY 2011-2012

Non Detox Reasons for Discharge

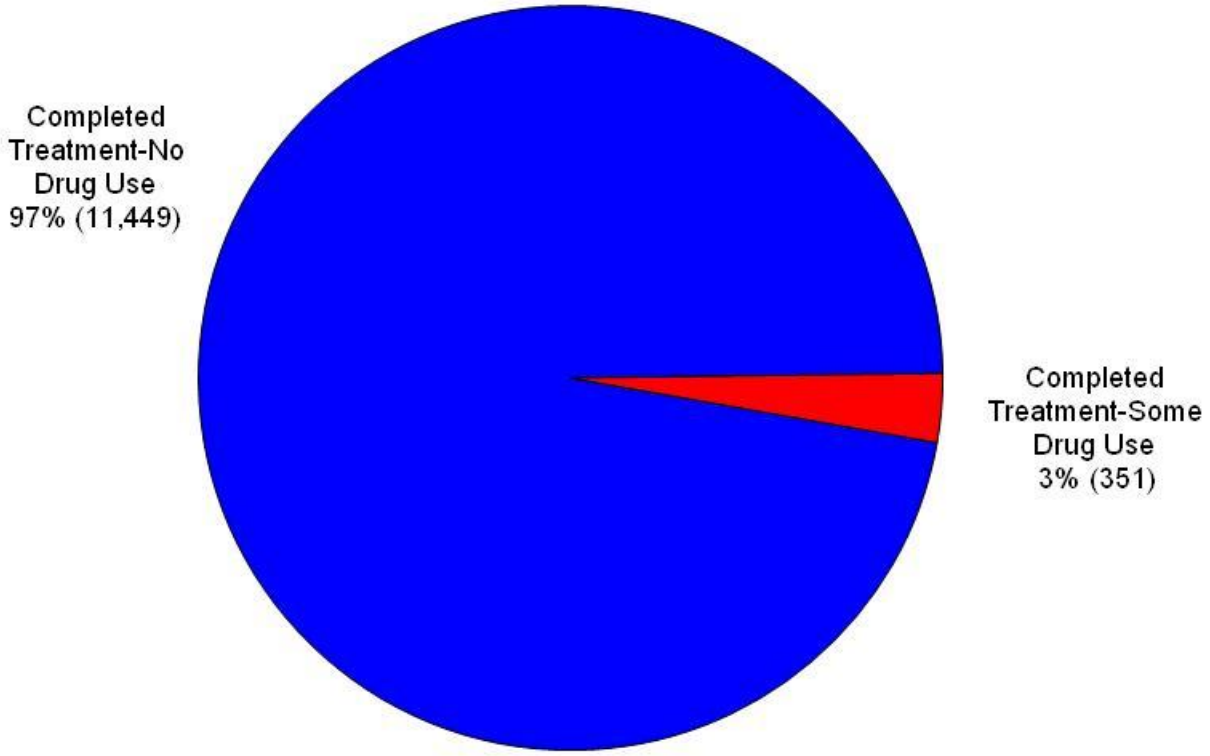


*Other Reasons includes: Referred to Another Drug and Alcohol Facility, Jailed, Completed Treatment-Some Drug Use, Relocation, Medical, Referred to a Non-Drug and Alcohol Facility, and Death.
Total Discharges=23,427

Figure 20

CIS Discharges SFY 2011-2012

Non Detox Reasons for Discharge
for those who completed treatment



Total Discharges Completing Treatment=11,800

Outcome Measures

Outcome measures show how much clients have changed during their time in substance abuse treatment. A certain characteristic of a client is recorded when he or she is admitted to treatment and when he or she is discharged from treatment. The amount of change in these characteristics between admission and discharge is then recorded as an outcome measure.

The following outcomes are collected for all clients for the federally required National Outcome Measures (NOMs). The results will be presented, even though these specific metrics may not always be part of each individual client's treatment goals.

Employment

The employment outcome measure records if the client is employed (full-time, part-time or student) at admission and discharge. Overall, clients improved from 30% employed at admission to 34% employed at discharge (Figure 21).

Arrests

The arrests outcome measure records the client's arrest status. At admission, the client is asked if he has been arrested in the **two years previous to admission.** At discharge, the client is asked if he has been arrested **since entering treatment.**

Because of the large difference in period of time in which arrests could have occurred at admission versus discharge, the admission numbers are most likely artificially higher than the discharge numbers. This makes the admission numbers more of a classification status (involvement with criminal justice) than a baseline measurement to show change. However, only 3% of clients were arrested in the time they were engaged in treatment programs (Figure 22). No significant changes occurred from previous years.

Alcohol Abstinence

The alcohol abstinence outcome measure records whether the client is abstinent from alcohol in the 30 days prior to admission and discharge. Only those clients listing alcohol as a drug of choice (primary, secondary or tertiary) are considered for the calculation. Overall, clients improved from 38% abstinent at admission to 70% abstinent at discharge (Figure 23). No significant changes occurred from previous years.

Other Drug Abstinence

The other drug abstinence outcome measure records whether the client is abstinent from other drugs in the 30 days prior to admission and discharge. Only those clients listing non-alcohol substances as a drug of choice (primary, secondary or tertiary) are considered for the calculation. Overall, clients improved from 30% abstinent at admission to 64% abstinent at discharge (Figure 24).

The somewhat high percentage of those already abstinent from alcohol and other drugs (38% and 30%, respectively) at admission occurs in part because the CIS requires a new admission each time a client changes type of service or provider. Many admissions (26%) were referred

from a drug and alcohol service provider. Therefore, these clients have already been in drug and alcohol service and may have already begun abstaining from substances. No significant changes occurred from previous years.

Figure 21

Outcome Measure Employment Status State Fiscal Year 2011-2012

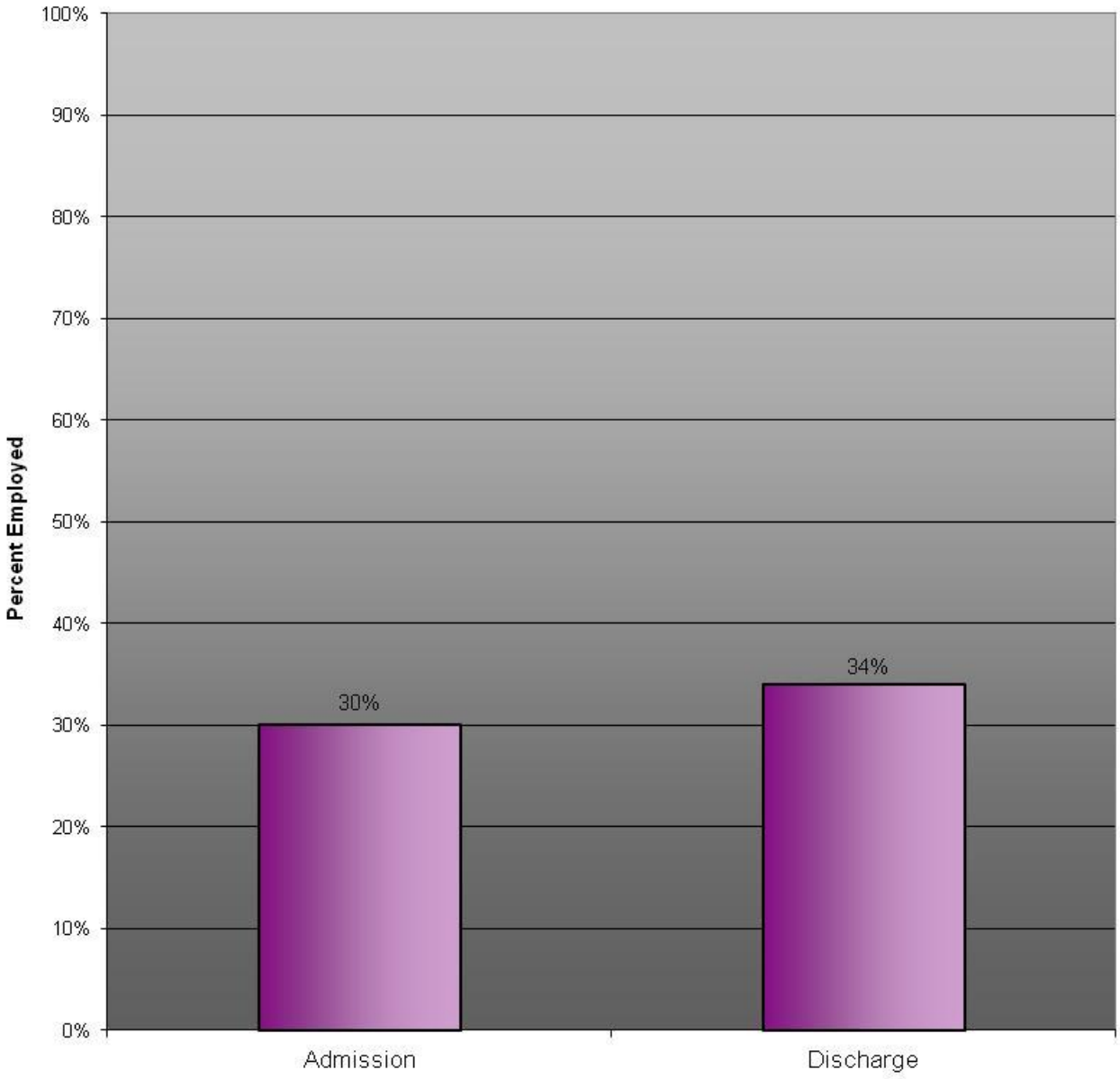


Figure 22

Outcome Measure Without Arrests State Fiscal Year 2011-2012

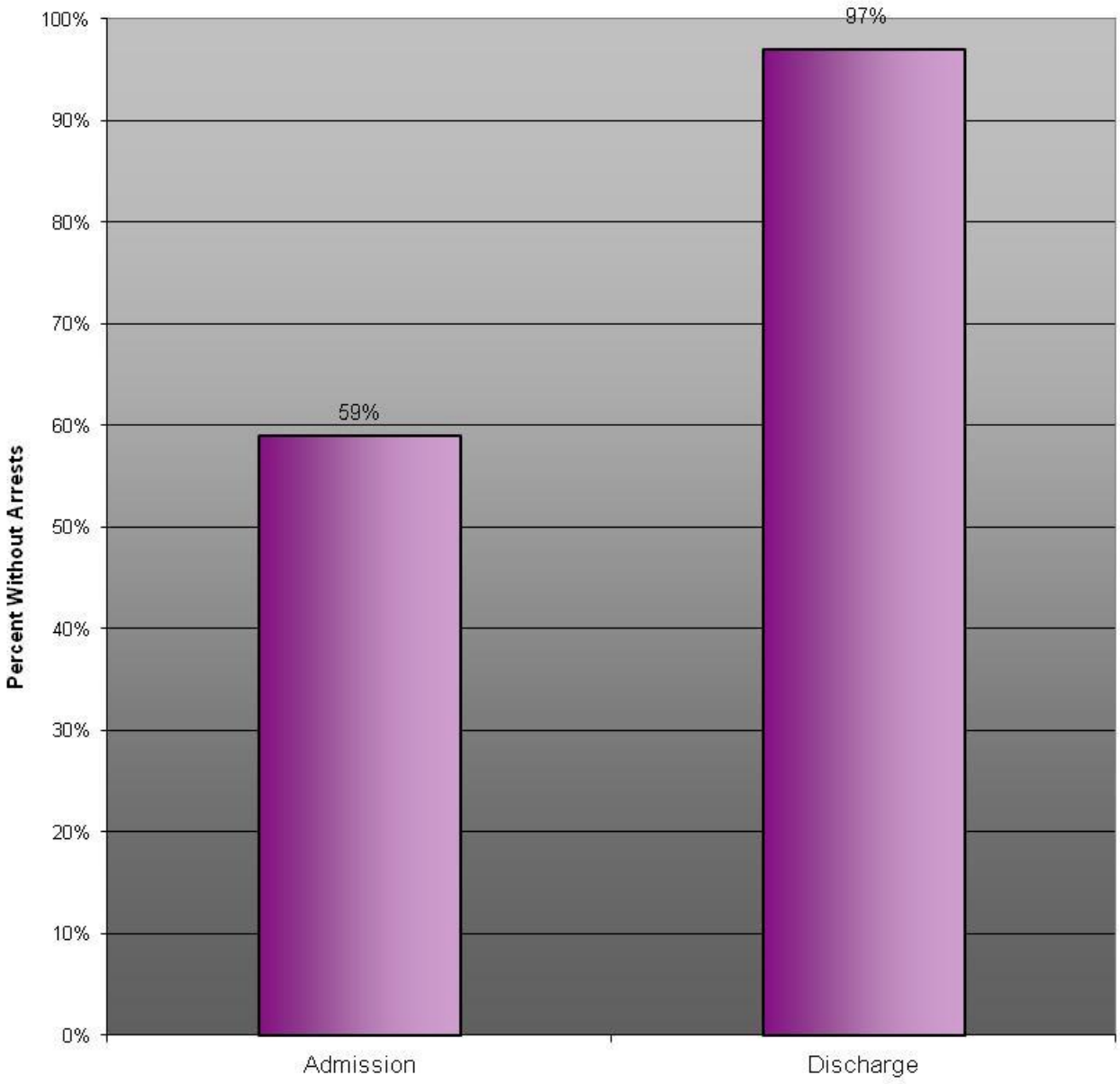


Figure 23

Outcome Measure
Alcohol Abstinence
State Fiscal Year 2011-2012

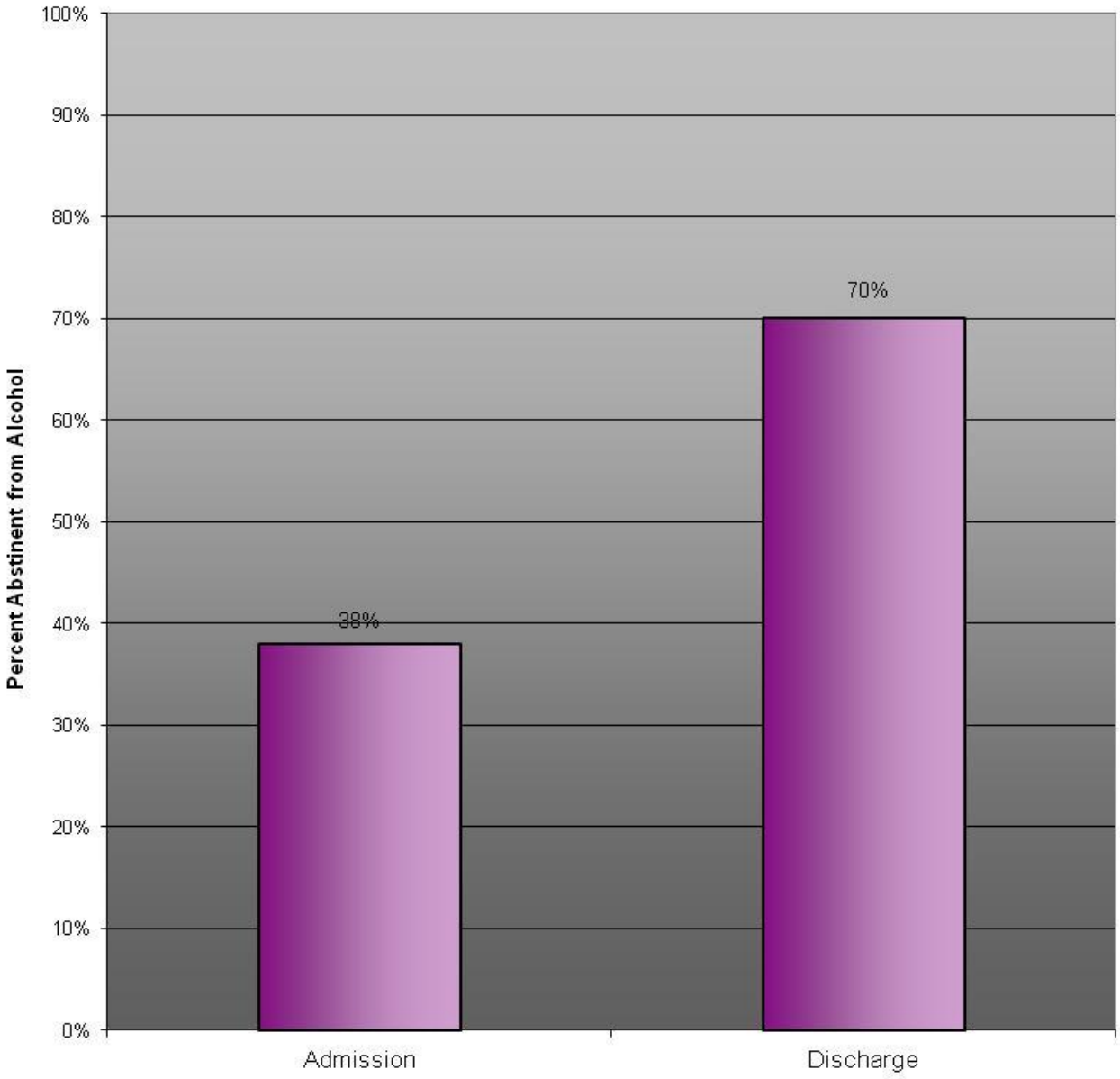
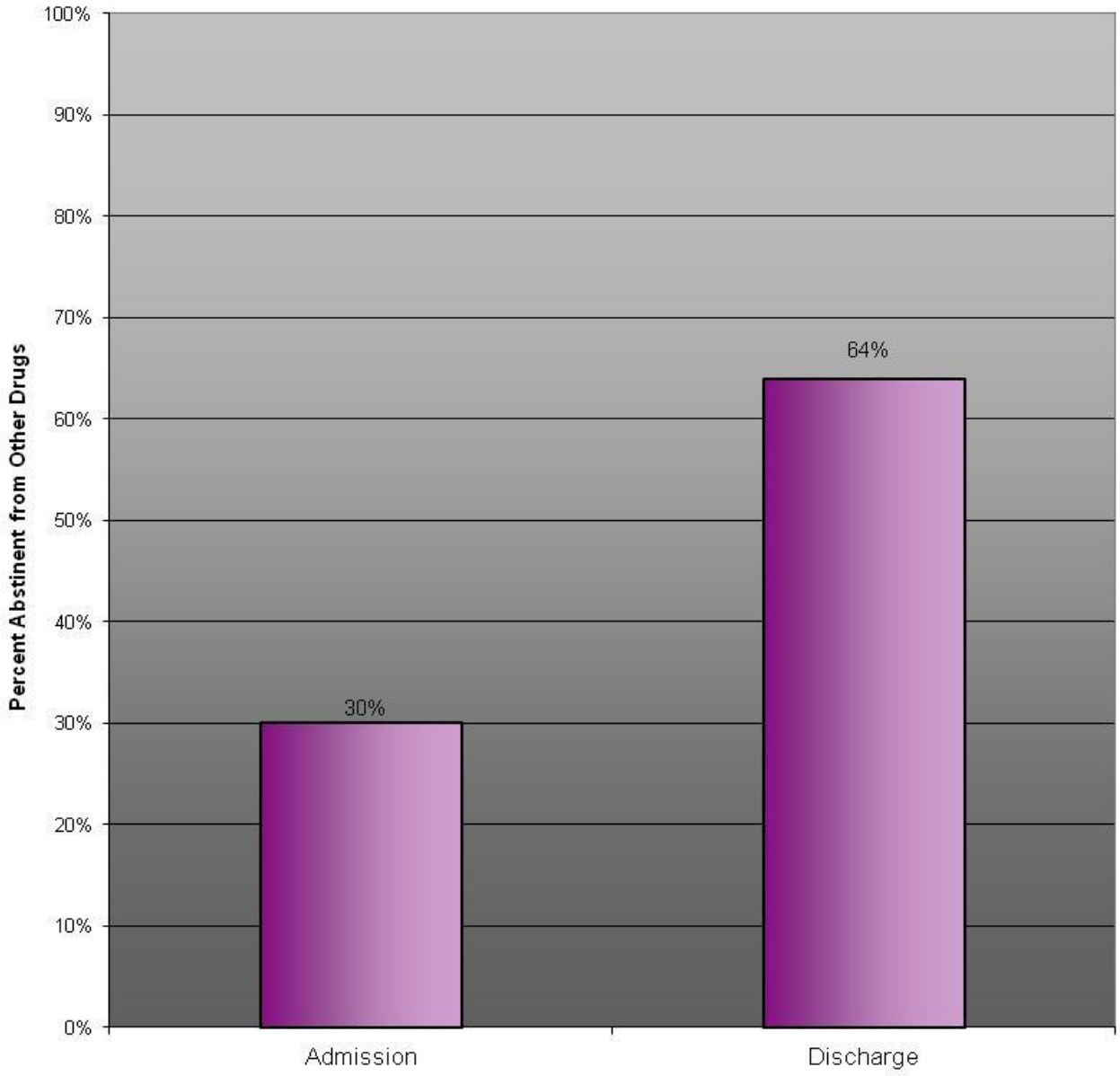


Figure 24

Outcome Measure
Other Drug* Abstinence
State Fiscal Year 2011-2012



*Other Drugs includes: Cocaine/Crack, Marijuana/Hashish, Heroin, Other Opiates/Synthetics, Non-Prescription Methadone, PCP, Other Hallucinogens, Methamphetamines, Other Amphetamines, Other Stimulants, Benzodiazepine, Other Tranquilizers, Barbiturates, Other Sedatives, Inhalants, Over-the-Counter, and Other Drugs

Single County Authority (SCA) Expenditures by Fund Source State Fiscal Year 2011/12 (All Sources)				
Single County Authority	Total DDAP (BDAP) Funds	Total County Funds	Total Other SCA Funds	Total Funds
Allegheny	$ 11,819,932	$ 233,707	$ 6,419,756	$ 18,473,395
Armstrong/Indiana/Clarion	$ 1,679,760	$ -	$ 1,872,985	$ 3,552,745
Beaver	$ 1,352,885	$ 75,000	$ 659,060	$ 2,086,945
Bedford	$ 489,535	$ -	$ 287,669	$ 777,204
Berks	$ 3,273,140	$ 1,744,684	$ 2,786,060	$ 7,803,884
Blair	$ 1,108,864	$ -	$ 1,179,654	$ 2,288,518
Bradford/Sullivan	$ 530,065	$ 19,995	$ 30,094	$ 580,154
Bucks	$ 3,524,433	$ 380,714	$ 1,926,210	$ 5,831,357
Butler	$ 1,111,074	$ 33,979	$ 1,170,123	$ 2,315,176
Cambria	$ 1,078,473	$ 29,612	$ 551,564	$ 1,659,649
Cameron/Elk/McKean	$ 837,334	$ 81,725	$ 1,101,108	$ 2,020,167
Carbon/Monroe/Pike	$ 1,020,057	$ 68,345	$ 1,693,307	$ 2,781,709
Centre	$ 836,060	$ 22,029	$ 661,227	$ 1,519,316
Chester	$ 2,602,916	$ 543,307	$ 4,023,290	$ 7,169,513
Clearfield/Jefferson	$ 1,044,695	$ -	$ 873,143	$ 1,917,838
Col/Montour/Snyder/Union	$ 830,012	$ 9,537	$ 619,049	$ 1,458,598
Crawford	$ 777,800	$ 22,000	$ 1,143,656	$ 1,943,456
Cumberland/Perry	$ 1,637,673	$ 203,227	$ 1,218,280	$ 3,059,180
Dauphin	$ 2,439,376	$ 141,167	$ 733,515	$ 3,314,058
Delaware	$ 3,589,063	$ 113,737	$ 2,182,722	$ 5,885,522
Erie	$ 3,652,260	$ 290,321	$ 1,252,424	$ 5,195,005
Fayette	$ 1,143,513	$ -	$ 1,523,829	$ 2,667,342
Forest/Warren	$ 439,292	$ 14,752	$ 283,171	$ 737,215
Franklin/Fulton	$ 610,968	$ 81,120	$ 553,194	$ 1,245,282
Greene	$ 409,561	$ 8,990	$ 199,787	$ 618,338
Huntingdon/Mifflin/Juniata	$ 736,689	$ -	$ 328,233	$ 1,064,922
Lackawanna/Susquehanna	$ 1,846,718	$ 82,500	$ 1,053,387	$ 2,982,605
Lancaster	$ 2,517,664	$ 160,465	$ 1,550,718	$ 4,228,847
Lawrence	$ 827,496	$ -	$ 658,467	$ 1,485,963
Lebanon	$ 632,635	$ 65,447	$ 446,481	$ 1,144,563
Lehigh	$ 2,309,204	$ 117,625	$ 2,105,911	$ 4,532,740
Luzerne/Wyoming	$ 2,296,538	$ 324,884	$ 1,580,469	$ 4,201,891
Lycoming/Clinton	$ 1,153,926	$ 73,100	$ 1,392,186	$ 2,619,212
Mercer	$ 1,128,450	$ 47,500	$ 881,260	$ 2,057,210
Montgomery	$ 4,170,859	$ 153,775	$ 1,732,827	$ 6,057,461
Northampton	$ 1,703,792	$ 246,010	$ 1,088,548	$ 3,038,350
Northumberland	$ 541,198	$ 27,860	$ 260,419	$ 829,477
Philadelphia	$ 25,551,932	$ 903,723	$ 17,444,958	$ 43,900,613
Potter	$ 175,255	$ 23,003	$ 70,920	$ 269,178
Schuylkill	$ 1,228,871	$ 23,594	$ 896,040	$ 2,148,505
Somerset	$ 547,096	$ 16,406	$ 113,289	$ 676,791
Wayne	$ 309,204	$ 117,380	$ 192,594	$ 619,178
Tioga	$ 337,337	$ 38,752	$ 97,563	$ 473,652
Venango	$ 449,413	$ 14,835	$ 450,291	$ 914,539
Washington	$ 1,539,437	$ -	$ 978,609	$ 2,518,046
Westmoreland	$ 2,697,899	$ 38,302	$ 1,088,426	$ 3,824,627
York/Adams	$ 1,997,303	$ 228,857	$ 1,473,021	$ 3,699,181
TOTAL	$ 102,537,657	$ 6,821,966	$ 70,829,494	$ 180,189,117

Single County Authority (SCA) Expenditures by Major Activity State Fiscal Year 2011/12 (All Sources)				
Single County Authority	Total Administration	Total Prevention	Total Intervention	Total Treatment	Total Expenditure
Allegheny	$ 2,115,782	$ 2,156,017	$ 3,204,832	$ 10,996,764	$ 18,473,395
Armstrong/Indiana/Clarion	$ 444,731	$ 1,066,358	$ 136,147	$ 1,905,509	$ 3,552,745
Beaver	$ 396,757	$ 326,041	$ 5,309	$ 1,358,838	$ 2,086,945
Bedford	$ 141,584	$ 361,096	$ 24,248	$ 250,276	$ 777,204
Berks	$ 799,076	$ 1,206,330	$ 474,214	$ 5,324,264	$ 7,803,884
Blair	$ 200,888	$ 355,856	$ 509,809	$ 1,221,965	$ 2,288,518
Bradford/Sullivan	$ 118,840	$ 123,300	$ 10,402	$ 327,612	$ 580,154
Bucks	$ 1,041,753	$ 889,117	$ 927,704	$ 2,972,783	$ 5,831,357
Butler	$ 269,646	$ 428,482	$ 205,930	$ 1,411,118	$ 2,315,176
Cambria	$ 246,036	$ 276,399	$ 49,736	$ 1,087,478	$ 1,659,649
Cameron/Elk/McKean	$ 257,592	$ 238,861	$ 1,061	$ 1,522,653	$ 2,020,167
Carbon/Monroe/Pike	$ 399,449	$ 487,511	$ 79,356	$ 1,815,393	$ 2,781,709
Centre	$ 198,408	$ 345,177	$ 24,304	$ 951,427	$ 1,519,316
Chester	$ 1,056,605	$ 570,142	$ 8,398	$ 5,534,368	$ 7,169,513
Clearfield/Jefferson	$ 125,359	$ 641,375	$ 198,836	$ 952,268	$ 1,917,838
Col/Montour/Snyder/Union	$ 198,344	$ 160,875	$ 128,442	$ 970,937	$ 1,458,598
Crawford	$ 193,165	$ 304,974	$ 87,414	$ 1,357,903	$ 1,943,456
Cumberland/Perry	$ 287,188	$ 733,451	$ 92,868	$ 1,945,673	$ 3,059,180
Dauphin	$ 653,345	$ 829,019	$ 150,555	$ 1,681,139	$ 3,314,058
Delaware	$ 651,048	$ 775,482	$ 249,158	$ 4,209,834	$ 5,885,522
Erie	$ 354,643	$ 1,264,004	$ 635,778	$ 2,940,580	$ 5,195,005
Fayette	$ 231,131	$ 520,603	$ 272,480	$ 1,643,128	$ 2,667,342
Forest/Warren	$ 135,016	$ 92,471	$ 2,869	$ 506,859	$ 737,215
Franklin/Fulton	$ 226,954	$ 167,743	$ 13,900	$ 836,685	$ 1,245,282
Greene	$ 124,959	$ 163,111	$ -	$ 330,268	$ 618,338
Huntingdon/Mifflin/Juniata	$ 160,629	$ 263,595	$ 35,993	$ 604,705	$ 1,064,922
Lackawanna/Susquehanna	$ 315,288	$ 580,732	$ 225,382	$ 1,861,203	$ 2,982,605
Lancaster	$ 543,420	$ 1,256,343	$ 167,813	$ 2,261,271	$ 4,228,847
Lawrence	$ 186,974	$ 323,646	$ 8,995	$ 966,348	$ 1,485,963
Lebanon	$ 172,905	$ 177,243	$ 87,752	$ 706,663	$ 1,144,563
Lehigh	$ 429,103	$ 624,299	$ 333,104	$ 3,146,234	$ 4,532,740
Luzerne/Wyoming	$ 317,076	$ 651,361	$ 82,388	$ 3,151,066	$ 4,201,891
Lycoming/Clinton	$ 364,510	$ 347,423	$ 10,625	$ 1,896,654	$ 2,619,212
Mercer	$ 246,639	$ 559,632	$ 16,837	$ 1,234,102	$ 2,057,210
Montgomery	$ 772,760	$ 812,564	$ 374,954	$ 4,097,183	$ 6,057,461
Northampton	$ 390,417	$ 386,745	$ 155,118	$ 2,106,070	$ 3,038,350
Northumberland	$ 144,659	$ 80,838	$ 73,281	$ 530,699	$ 829,477
Philadelphia	$ 9,238,826	$ 5,262,441	$ 6,163,472	$ 23,235,874	$ 43,900,613
Potter	$ 71,052	$ 44,950	$ -	$ 153,176	$ 269,178
Schuylkill	$ 204,109	$ 487,469	$ 41,136	$ 1,415,791	$ 2,148,505
Somerset	$ 90,341	$ 129,625	$ 19,387	$ 437,438	$ 676,791
Wayne	$ 174,712	$ 100,821	$ 42,049	$ 301,596	$ 619,178
Tioga	$ 126,794	$ 67,391	$ -	$ 279,467	$ 473,652
Venango	$ 188,539	$ 148,438	$ 17,037	$ 560,525	$ 914,539
Washington	$ 346,054	$ 578,711	$ 16,724	$ 1,576,557	$ 2,518,046
Westmoreland	$ 560,819	$ 1,306,103	$ -	$ 1,957,705	$ 3,824,627
York/Adams	$ 360,933	$ 473,441	$ 14,080	$ 2,850,727	$ 3,699,181
Total	**$ 26,274,858**	**$ 29,147,606**	**$ 15,379,877**	**$ 109,386,776**	**$ 180,189,117**

State Plan Acronym List

ASAM	American Society of Addiction Medicine
ATR	Access to Recovery Grant
BTP	Buprenorphine Treatment Program
CSAT	Center for Substance Abuse Treatment
CSC	Clinical Standards Committee
DAAC	Drug and Alcohol Advisory Council
DDAP	Department of Drug and Alcohol Programs
DOC	Department of Corrections
DOH	Department of Health
DPW	Department of Public Welfare
FASD	Fetal Alcohol Spectrum Disorder
HCV	Hepatitis C Virus
IRETA	Institute for Research, Education, and Training in Addictions
MAT	Medication Assisted Treatment
OCYF	Office of Children, Youth and Families
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health and Substance Abuse Services
OTP	Opioid Treatment Program
PACDAA	PA Association of County Drug and Alcohol Administrators
PBPP	PA Board of Probation and Parole
PBPS	Performance Based Prevention System
PCB	PA Certification Board
PCPA	PA Community Providers Association
PCPC	PA Client Placement Criteria
PDE	PA Department of Education
PERU	Program Evaluation and Research Unit (University of Pittsburgh)
PPAC	Parent Panel Advisory Council
PRO-A	PA Recovery Organizations Alliance
ROSC	Recovery Oriented Systems of Care
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SBIRT	Screening, Brief Intervention and Referral to Treatment
SCA	Single County Authority
SCI	State Correctional Institution
STAR	Strengthening Treatment and Recovery Data System
VMS	Voucher Management System